**Reporting Bowel Left in Discontinuity**

June 14, 2018

**Question:**
What codes are reported if the bowel is left in discontinuity as part of damage control surgery?

**Answer:**
Since the bowel is resected but an anastomosis is not performed, report the appropriate bowel resection code with a 52 modifier for reduced services.

*This response is based on the best information available as of 06/14/18.*

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**Coding a Composite Graft with Harvested Cartilage**

June 14, 2018

**Question:**
I performed a composite graft (CPT 15760), and harvested cartilage from the ear. Can I report for the harvesting? If yes, what code do I use?

**Answer:**
You can report both 15760 (Graft; composite (eg, full thickness of external ear or nasal ala)), including primary
closure, donor area) and CPT 15040 (Harvest of skin for tissue cultured skin autograft, 100 sq cm or less) for harvesting the graft. These two codes are not bundled under the National Correct Coding Initiative and can be reported together.

*This response is based on the best information available as of 06/14/18.

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**Multiple Procedure Payment Formula**

June 14, 2018

**Question:**
What is Medicare’s multiple procedure payment formula? When I do more than one procedure, I know Medicare reduces payment for some but I can’t remember by how much.

**Answer:**
It used to be 100%, 50%, 25%, 25%, etc but many years ago the formula changed to the physician’s advantage and now is 100%, 50% for subsequent stand-alone procedures. Remember, add-on codes (+) and codes exempt from modifier 51 (⦸) are always paid at 100% of the allowable.

*This response is based on the best information available as of 06/14/18.
Piriformis Syndrome

June 14, 2018

Question:
What code do I use when my physician injects the piriformis muscle for piriformis syndrome under ultrasound guidance in the office? Do I report 64445 for the nerve injection?

Answer:
CPT code 20552 and 76942 for the ultrasound guidance. Per CPT Assistant April 2012; there is a significant difference in the work and procedure, as well as intent, between an injection of the piriformis muscle and the perineural injection of the sciatic nerve. The sciatic nerve injection code (64445) should not be used to report a piriformis injection. Piriformis muscle injection(s) should be reported using CPT code 20552, Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s).

*This response is based on the best information available as of 06/14/18.

Billing Diagnostic Angiograms and Lower Extremity
Interventions

June 14, 2018

Question:
I was told that diagnostic angiograms are always included in iliac, femoral and tibial angioplasty and stents. Is that true?

Answer:
No. Diagnostic angiograms with lower extremity revascularizations, are separately reported as long as the patient has not had a recent, adequate diagnostic angiogram. For CPT this means a catheter based angiogram. For Medicare this means a catheter based angiogram or a CTA. Remember, all catheterization is included in the lower extremity revascularization.

*This response is based on the best information available as of 06/14/18.

New Patient, or Not?

June 14, 2018

Question:
If I see a new patient in consultation for a suspicious lesion and release them to their primary care provider and they come back to see me for a skin problem one year later on their own, can I code them as a new patient?

Answer:
No. According to the CPT guidelines, a new patient is a patient that has not had any face-to-face service from you (or another physician of the same specialty in your practice) for the past three years. It is irrelevant that the first visit was a consultation and they came back on their own the second time.

*This response is based on the best information available as of 06/14/18.

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**Total Hip Arthroplasty**

**Question**

June 14, 2018

**Question:**

We have a patient who underwent an open fixation of a femoral neck fracture five years ago and now presents for a total hip arthroplasty. Someone mentioned that we should report a conversion to hip arthroplasty but we are not sure if this is a revision of one component plus a hemiarthroplasty?

**Answer:**

The advice you received related to reporting this as a conversion to total hip arthroplasty is correct. The patient is not in a global period, so you will report 27132 (Conversion of previous hip surgery to total hip arthroplasty, with or without autograft or allograft). The concept of reporting the conversion code versus a primary hip
arthroplasty is that the patient has had prior open hip surgery, and the value of the conversion code reflects that the procedure is typically more difficult than a primary arthroplasty procedure.

Do not unbundle and report the removal of one component and a hemi-arthroplasty or other revision codes for the described circumstance.

*This response is based on the best information available as of 06/14/18.*

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**Confused about CPT Code 26600**

May 31, 2018

**Question:**
I am confused on how to report the closed treatment of multiple metacarpal fractures (26600) that are not displaced and treated with the application of a fiberglass short arm cast. We are receiving denials when reporting the code for each fracture.

**Answer:**
The official definition of CPT code 26600 (Closed treatment of metacarpal fracture, single; without manipulation, each bone) instructs the physician to report CPT code 26600 for each bone that is fracture and treated without manipulation.

Several years ago, CMS implemented NCCI guidelines instructing that non-manipulative fractures that are treated with a single form of stabilization (e.g. cast) may only be reported as a single fracture. This NCCI guideline also applies to
situations where a patient may have both a displaced and non-displaced fracture treated with the same cast or splint.

The denials are correct if the payor is Medicare based on NCCI edits. If the denials are coming from private payors, review the contracts to determine if the claim processing rule is agreed to in the contracts. Appeal all denials to private payors citing CPT rules and hopefully contract agreement language.

*This response is based on the best information available as of 05/31/18.

Billing Renal Angiograms

May 31, 2018

Question:
The doctor documented a renal angiogram, and an aortogram. The aortogram was denied. What should we do?

Answer:
The denial was correct. Per CPT, an aortogram is included in a renal angiogram and should not be separately reported. See the code description below.

36251 Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiological supervision and interpretation, including pressure gradient measurements when performed, and flush
aortogram when performed; unilateral

*This response is based on the best information available as of 05/31/18.

**Coding for Multiple Joint Injections**

May 31, 2018

**Question:**
What CPT codes do I use to perform a right SI joint injection and then inject 4 spots along the left trapezius? I use Fluoroscopy for guidance for the SI joint injection, but not for the trigger point.

**Answer:**
Use CPT code 27096-RT (Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed) and CPT code 20552-59 or XS (Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s). CPT code 20552 is bundled if performed at the same anatomic location. In this case the trigger point was performed at a separate anatomic area. The 59 modifier tells the payor that the two procedures were performed at different anatomic areas.

*This response is based on the best information available as of 05/31/18.*