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.

Surgical Coding after Excessive Weight Loss after Gastric Bypass

May 31, 2018
Question:
How do I code an abdominoplasty with a panniculectomy? I am reporting 15830 for the excision of the excessive skin. Does CPT 15830 include the abdominoplasty?

Answer:
In addition to CPT 15830 for the panniculectomy when you are also doing an abdominoplasty during the same operative session you can report the add-on code 15847 (Excision, excessive skin, and subcutaneous tissue (includes lipectomy), abdomen (e.g., abdominoplasty) (includes umbilical transposition and fascial plication) (List separately in addition to code for primary procedure).

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

FAST (Focused Assessment with Sonography in Trauma) Exams

May 31, 2018

Question:
We routinely do FAST studies as part of the work-up for trauma patients. Can the trauma surgeon bill for these studies?

Answer:
Yes, the trauma surgeon may report/bill for these studies if two criteria are met. First, the ultrasound equipment used must be capable of retaining a permanent image. Next, the physician must document these studies in a separate paragraph
of the EM note, describing the structures visualized and the findings in each. Describing the results of these studies in the text of the EM note is not sufficient to report and bill these separately.

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

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Eustachian Tube Dilation

May 31, 2018

**Question:**
We want to start doing this new procedure but can’t find a code for it. What do you suggest?

**Answer:**
You’re correct – currently there is not a specific CPT code for the procedure. Therefore, you’ll need to use an unlisted code such as 69799, Unlisted procedure of the middle ear.

*This response is based on the best information available as of 05/31/18.*
ICD-10-CM Code for DBS Battery/Generator Replacement

May 31, 2018

Question:
We are using the diagnosis code of T85.190 (Other mechanical complication of implanted electronic neurostimulator of brain electrode (lead), initial encounter) for the replacement of a deep brain stimulator generator (2 leads, 61886) because the battery died. This code requires a 7th digit and we are struggling with the difference between initial encounter (A) and subsequent encounter (D) for this case. It’s not an injury or fracture which makes it more difficult to decide. Can I get your expertise?

Answer:
A couple of questions/ comments about this:

1. Why are the leads being replaced? Are they dislodged or out of place? If so, then a T code is appropriate.
2. For routine battery replacements because the battery has reach its end of life (a normal occurrence – not a complication), we’d use the condition code such as Parkinson’s disease (G20) and not a T code.

If you’re using a T code then you have 3 choices for the 7th character: A for initial encounter, D for subsequent encounter, and S for sequela. The service is not being performed for a sequela so you can eliminate the 7th character of S. So now you’re between A and D. Since the patient is receiving active treatment for the “other mechanical complication”, you’ll use the 7th character of A (T85.190A).

*This response is based on the best information available as of 05/31/18.
Bilateral Modifier: Use or Not use?

May 31, 2018

Question:
If a patient has a biopsy on the right cheek and one on the left forehead, do we need to put modifiers RT and LT on the codes (11100-RT, 11101-LT)?

Answer:
No. The skin is part of the integumentary system, actually the largest organ system in the body. The concept of laterality does not apply to skin.

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

Soft Tissue Tumors

May 17, 2018

Question:
I performed a soft tissue tumor of the neck 5cm with an intermediate repair on a Medicare patient. I coded 21552 and
12042 for the repair. The claim for the repair was denied. I am not certain why the repair was not paid. I performed the procedure. Can I file an appeal?

Answer:
No, you cannot report the intermediate repair not matter who the payor is. The soft tissue tumor code 21552 includes either a simple or intermediate repair. Only a complex repair or more extensive close such as an adjacent tissue transfer, flap or graft can be reported in addition to the excision.

*This response is based on the best information available as of 05/17/18.

Carotid Stenting and Diagnostic Angiograms

May 17, 2018

Question:
I was told that no diagnostic angiogram can be billed with a carotid stent. Is this true?

Answer:
Not exactly! Any carotid angiograms on the ipsilateral (same) side are included in a carotid stent procedure. Medically necessary diagnostic carotid stenting on the contralateral side and vertebral angiography on either side are separately reportable.

*This response is based on the best information available as of 05/17/18.