Medical Necessity Audits

**Question:**

Our Medicare carrier has asked for several patient records from our pain center. They say they are conducting a “medical necessity audit”. What does that mean?

**Answer:**

Most Medicare carriers have a written coverage policy, referred to as a local carrier determination or LCD, that delineates the signs, symptoms, ultrasound findings and more, that must be present to justify coverage of specific types of procedures. These represent the payor’s medical necessity criteria for payment. If you have not followed the coverage criteria to the letter, you may be at risk for a significant repayment. KZA consultants have assisted many practices undergoing these medical necessity audits. Talk to your health care attorney and consider asking a consultant to review your records to identify your risk areas.

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Laminectomy/Facetectomy/Foram inotomy for Decompression (CPT 63047)

**Question:**

I recently attended a coder’s meeting and the speaker said when doing a decompression laminectomy at L4-L5 (using 63047) that we should report two codes (63047 and 63048) because L4 is one level and L5 is another. I’ve been using one code when
the procedure is performed at L4-L5. Have I been coding incorrectly?

Answer:

It sounds like you have been doing it the right way. To clarify, if the procedure is performed at L4-L5, meaning the inferior L4 lamina and superior L5 lamina are removed as well as a foraminotomy at L4-L5 to decompress the exiting nerve root, you will report only one CPT code (63047). To report a second code, 63048, the surgeon will need to remove more of the lamina at either L4 or L5 and do a foraminotomy with decompression of a different exiting nerve root such as at L3-L4 or L5-S1.

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**Craniotomy for Biopsy**

**Question:**

For craniotomy for tumor biopsy-not removal, would craniotomy exploratory should be used-61304 or craniectomy for brain tumor-61510?

**Answer:**

CPT code 61510 is specifically for a craniotomy for excision of a brain tumor and is intended for tumor resection. For a craniotomy for tumor biopsy, report code, 61304, craniectomy or craniotomy: exploratory if supratentorial and 61305 if infratentorial.
Question:

I heard at a seminar that diagnostic angiograms performed at the same operative session as an aneurysm coiling, 61624 cannot be billed. Is that true?

Answer:

No that is not exactly true. According to CPT, diagnostic angiograms performed at the time of an interventional procedure may be separately reported if:

- No prior catheter-based angiographic study is available and a full diagnostic study is performed and the decision to intervene is based on the diagnostic study OR
- A prior study is available but as documented in the medical record is that:
  - The patient's condition has changed since the prior study
  - There is inadequate visualization of the anatomy and/or pathology on that study
  - There is a clinic change during the procedure that requires a new evaluation outside the target area of intervention

One of these conditions should be documented in the operative note; ideally in the Indications for Procedure section of the procedure note. It must be clear that one of these conditions existed to justify a diagnostic study at the same time as an intervention (e.g., coiling).
360 Degree Fusion on the Same Day

Question:
My spine surgeon did an anterior procedure followed by a posterior procedure on the same day (same patient, same anesthesia). I was told to send in two separate claims – one for the anterior procedure and the other for the posterior procedure – to get better reimbursement. I was also told to use modifier 58. Something doesn’t seem right about this. What do you think?

Answer:
You are wise to question this advice. First, modifier 58 (staged or related procedure or service by the same physician during the postoperative period) is used on the second procedure when it is performed in the global period of the first procedure. A 360 degree (or front-back) procedure is performed entirely on the same surgical day, therefore, it is inappropriate to use modifier 58 in this situation.

Sending the procedures on two separate claims to avoid the multiple procedure payment reduction is not appropriate. We expect a payment reduction for secondary stand-alone procedures when performed on the same day due to overlapping pre- and post-operative global periods and activity.
**Assistant Surgeon with Stereotatic Navigation Planning**

**Question:**

My doctors want me to submit 61781 for both the primary and assistant on the operative note. The payor denied it and I’m wondering if there is something else I need to do to get it paid.

**Answer:**

CPT 61781 (Stereotactic computer-assisted (navigational) procedure; cranial, intradural (List separately in addition to code for primary procedure)) is an add-on code for the surgeon’s pre-incision, pre-procedure as well as intraoperative work of stereotactic navigation for an intradural cranial procedure. This involves cognitive work and image manipulation at a computer workstation which occurs prior to surgery and the utilization of the navigation system during the procedure. This activity does not require an assistant, so it is appropriate that a payor would deny payment for an assistant surgeon on 61781.

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**Angiogram Global Period**

**Question:**

We have a new neuroendovascular surgeon and I’m trying to figure out his coding – it’s complicated! I know the code for coiling an aneurysm is 61624. Do I need a global period
modifier on this code because he did the coiling two days after the diagnostic angiogram?

Answer:

Yes, indeed neuroendovascular coding can be complicated. That’s exactly why we developed a product called GPS for Neuroendovascular Coding. The easy to use laminated graphics provide a visual roadmap of the arteries and corresponding codes to take the confusion out of coding neuroendovascular procedures. Click here to purchase GPS for Neuroendovascular Coding.

The global period for the catheterization codes is 0 days; therefore, you should not need a global period modifier on 61624 when you coil an aneurysm on a different day after an angiogram.

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**Minimally Invasive Spine Surgery**

**Question:**

We are just starting to do minimally invasive spine surgery through a tubular retractor system. One of the procedures we do is multi-level decompression through separate skin/fascial incisions. For example, we will do left L5-S1, right L5-S1, left L4-L5, and right L4-L5 procedures through separate incisions. I’ve been told we can bill the decompression code four times since there are four separate incisions. Is this correct?

**Answer:**
No, this advice is not correct. You will code the case just as you would if performed via an open approach. This means you’ll use a single stand-alone code (e.g., 63047) and any appropriate add-on codes (e.g., 63048) as appropriate.

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**Burr Holes and Craniotomy**

**Question:**

We billed 61156 for the burr holes and 61312 for the craniotomy to removal a subdural hematoma. The insurance company denied 61556 but paid 61312. I’ve appealed the denial twice but they are adamant about not paying. I’m thinking about balance billing the patient for this charge. What do you think I should do?

**Answer:**

We think you should just write off your charge for 61156. This code should not have been billed in the first place because making the burr holes is included in all craniotomy codes. It is not appropriate to balance bill the patient for a charge that should not have been billed. The only time separate burr holes are billable are when they are performed as a completely separate procedure and not a part of the craniotomy exposure.

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**Stereotactic Radiosurgery of**
Multiple Brain Tumors

Question:

My neurosurgeon participated in a stereotactic radiosurgery case where 10 separate metastatic brain lesions were radiated. They all were small so the lesions are considered “simple” from a CPT perspective. I billed 61796 for the first lesion and the add-on code, 61797, times 9 units for the remaining lesions. We got paid for 61796 but the 61797 x 9 units line was denied for “exceeds number of units.” What does that mean?

Answer:

CPT directs physicians to report a stereotactic radiosurgery add-on code (61797 or 61799) no more than 4 times regardless of number of lesions treated. So when you billed 61797 x 9 units, you went over the limit of 4 units allowed by CPT coding (an ultimately payor) rules. You’ll need to submit a corrected claim with only 4 units of 61797. The remaining 4 lesions cannot be billed when treated on the same day as the first 5 lesions.