Endoscopic Skull Base Surgery

January 14, 2016

Question:
We are thinking about starting an endoscopic skull base surgery program and doing skull base procedures via an expanded endonasal/endoscopic approach. I’ve looked in the CPT book for codes and it looks like CPT 61580-61619 are just what I’m looking for. Is this correct?

Answer:
That’s great that you’re starting a new program! We can help. There is one CPT code for an endoscopic skull base procedure – 62165, Neuroendoscopy, intracranial; with excision of pituitary tumor, transnasal or trans-sphenoidal approach.

However, other procedures that you’ll do such as an endoscopic resection of a clival chordoma are not accurately coded using 61580-61619, as these existing codes are for open procedures. We wrote an article for the AAO-HNS Bulletin about this a few years ago that I think you’ll find helpful. Here are the links:

Sample Prior Authorization, Cover Letter, or Appeal Letter for the Otolaryngologist’s Use of an Unlisted CPT Code for Endoscopic/Endonasal Skull Base Surgery

Coding and Reimbursement Strategies: Using an Unlisted Code for Endoscopic Skull Base Surgery

*This response is based on the best information available as of 01/14/16.*
Harvest of Abdominal Fat Graft

December 17, 2015

Question:
My doctor harvested abdominal fat that he then used in the nose to close the area when he did an endoscopic removal of a pituitary tumor (62165). I want to bill 15770, but my doctor thinks the correct code is 20926. What do you recommend?

Answer:
Your doctor is correct with 20926 (Tissue grafts, other (e.g., paratenon, fat, dermis)). CPT 15770 (Graft; derma-fat-fascia) is used for a composite graft when more than one layer of tissue is harvested and placed (e.g., fat and fascia). When only one layer of tissue is harvested, such as fat, report 20926.

*This response is based on the best information available as of 12/17/15.

Removal of Spinal Cord Stimulator

12/03/15

Question:
My doc removed an electrode plate previously placed via laminectomy – 63662. At the same time, he removed the pulse generator – 63688. Is the removal of the generator considered
a secondary procedure and therefore reduced in reimbursement by 50%?

Answer:

Yes, that’s correct. CPT 63662 is the higher valued code so it should be paid at 100% of the payer allowable. The generator removal, 63688, is the lower valued code and CPT says to report it with modifier 51 (multiple procedures).

Therefore, 63688 will typically be reduced by the payer’s multiple procedure payment formula (MPPF). Medicare’s MPPF is 50% for secondary stand-alone procedures.

*This response is based on the best information available as of 12/03/15.

Harvest of Abdominal Fat Graft

November 5, 2015

Question:

My doctor harvested abdominal fat that he then used in the nose to close the area when he did an endoscopic removal of a pituitary tumor (62165). I want to bill 15770, but my doctor thinks the correct code is 20926. What do you recommend?

Answer:

Your doctor is correct with 20926 (Tissue grafts, other (e.g., paratenon, fat, dermis)). CPT 15770 (Graft; derma-fat-fascia) is used for a composite graft when more than one layer of tissue is harvested and placed (e.g., fat and fascia). When
only one layer of tissue is harvested, such as fat, then report 20926.

*This response is based on the best information available as of 11/05/15.

---

**+22851 vs. +20931**

October 22, 2015

**Question:**

We’ve been told we cannot bill +22851 and +20931 with the ACDF code, 22551. Is this true?

**Answer:**

It is true if you are thinking about reporting +22851 (intervertebral device) and +20931 (structural allograft) at the same spinal level. For example, you would not use a PEEK device (+22851) and a structural allograft (+20931) in the same interspace such as at C5-C6. Rather, you would use one or the other.

However, if different products are used at different levels, then it is acceptable to report both codes. For example, a PEEK device is placed at C5-C6 while a structural allograft is placed at C6-C7.

*This response is based on the best information available as of 10/22/15.*
1997 CMS Neurological Exam

October 8, 2015

Question:

Please explain the difference between the Eyes exam bullet and the bullet for the exam of cranial nerves 3, 4 and 6.

Answer:

The exam element for the Eyes states “Ophthalmoscopic examination of optic discs (e.g., size, C/D ratio, appearance) and posterior segments (e.g., vessel changes, exudates, hemorrhages).” This requires use of an ophthalmoscope and examination of the posterior segments including the optic discs.

Exam of cranial nerves 3, 4 and 6 does not require the use of an ophthalmoscope. Rather, the neurosurgeon observes eye movements and the pupils to determine cranial nerve function.

*This response is based on the best information available as of 10/08/15.

ICD-10-CM for Bilateral Carpal Tunnel Syndrome

September 10, 2015

Question:

I noticed that the ICD-10 carpal tunnel syndrome diagnosis codes are specific for right and left. What happens if the
patient has bilateral carpal tunnel syndrome – how should I code it?

Answer:

Good question, because many ICD-10-CM codes have right, left and bilateral codes; although the codes for carpal tunnel syndrome do not have a bilateral option. Here’s what we’ve got in ICD-10-CM for carpal tunnel syndrome:

G56.01 Carpal tunnel syndrome, right upper limb
G56.02 Carpal tunnel syndrome, left upper limb

But there is not a code for bilateral carpal tunnel syndrome. So if the patient has bilateral carpal tunnel syndrome, you will use both ICD-10-CM codes: G56.01 and G56.02.

*This response is based on the best information available as of 09/10/15.*

---

63005 vs. 63047

August 27, 2015

Question:

Help me understand the difference between 63005 and 63047 – I don’t get it! The codes look the same to me.

Answer:

Yes, it can be confusing because the code descriptions are very similar. However, look very carefully and you’ll see the differences. Here are the code descriptions and I’ve bolded some key differences:
<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>63005</td>
<td>Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, (e.g., spinal stenosis), one or two vertebral segments; lumbar, except for spondylolisthesis</td>
</tr>
<tr>
<td>63047</td>
<td>Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (e.g., spinal or lateral recess stenosis)), single vertebral segment; lumbar</td>
</tr>
</tbody>
</table>

CPT 63005 is generally used for removal of the lamina to provide central decompression of the spinal cord. CPT 63047 involves not only removal of lamina for central decompression but also lateral recess decompression in the form of a facetectomy (e.g., medial, partial) and/or foraminotomy for nerve root decompression.

*This response is based on the best information available as of 08/27/15.*

---

**Bilateral Diagnoses**

August 13, 2015

**Question:**

I understand there are more diagnosis codes for bilateral procedures in ICD-10-CM. This makes sense and I get it. But I noticed that there are some diagnosis codes that don’t have a “bilateral” option. What should we do?

**Answer:**
Good question! And we agree that having some diagnosis codes that reflect laterality is a good idea. Some of the ICD-10-CM cerebrovascular diagnosis codes have right, left and bilateral options. However, some don’t have a bilateral option. The same is true for carpal tunnel syndrome – there are right and left diagnosis codes but not a bilateral code. So how should you code if a diagnosis is bilateral and a bilateral code does not exist? You’ll use both the right and left diagnosis codes in those cases. We cover this issue and many more in our two neurosurgery-specific ICD-10-CM webinars that you can find here: