**Abdominal Fat Graft**

October 5, 2017

**Question:**
I billed 15770 (Graft; derma-fat-fascia) for an abdominal fat graft. After reviewing my operative report, the insurance company denied the code saying it was wrong. What code should I use?

**Answer:**
CPT 15770 is a composite graft meaning more all layers – dermis, fat and fascia – are used to repair a defect. In your situation, you used only one layer – fat. Therefore, the correct code is 20926, Tissue grafts, other (eg, paratenon, fat, dermis).

*This response is based on the best information available as of 10/05/17.*

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**Endoscopic Sphenopalatine Artery Ligation**

September 21, 2017

**Question:**
I did an endoscopic ligation of the left sphenopalatine artery for recurrent epistaxis in a patient with Coumadin-induced coagulopathy. I don’t see a CPT code for this procedure – can I use 30920?
Answer:
No, you’ll need to use an unlisted code such as 30999. Your comparison code can be 30920 (Ligation arteries; internal maxillary artery, transantral). However, using 30920 is not accurate as this code requires a transantral approach (which you didn’t do) and it requires ligation of the internal maxillary artery (which wasn’t done). That said, be on the lookout in 2018 as there may likely be a new CPT code for this procedure. Kim Pollock will be doing a webinar with the 2018 coding updates for ENT as it appears there will be several!

*This response is based on the best information available as of 09/21/17.

Post-Op hemorrhage repair. Is it billable?

September 7, 2017

Question:
Can I bill for taking the patient back to the OR to explore and repair post-op hemorrhage on day post-op? I heard that all complications are included in the payment of the original surgery.

Answer:
Yes, you may bill for this. CPT and Medicare agree that taking the patient back to the OR to treat a complication is billable. A modifier 78, unplanned return to the OR) is appended to the procedures performed to treat the hemorrhage. The appropriate ICD-10 code for a postoperative hemorrhage
Global Period for Surgery. Is it billable?

August 24, 2017

**Question:**
My patient presented to the ED with an infection at the incision site from a surgery that I did 4 weeks ago. It has a 90 day global. I was on vacation so my general surgeon partner saw the patient and admitted her. What should she bill for this?

**Answer:**
Since the patient is in a global period for the surgery, this is not billable, by you or any of your partners of the same specialty.

From a billing perspective, you and your partners are a single billing entity. Therefore, you all share the global package of the patient’s surgery.

*This response is based on the best information available as of 08/24/17.*
**Assistant Surgeon Payments**

August 10, 2017

**Question:**
We are seeing payers ask for payment back when we use Modifier 80 for assistant surgeon. Is there a reason why they would take the payment back?

**Answer:**
We are seeing many payers including Medicare and Medicaid ask for payment recovery when the documentation does not explain what role the assistant played in the surgery. It is not enough just to identify that the patient encounter is complex but actual detail of what the assistant did during the surgery can support billing for an assistant surgeon.

*This response is based on the best information available as of 08/10/17.*

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**Closure After Moh’s Surgery**

July 27, 2017

**Question:**
I did the closure for a patient’s left ear defect after the Moh’s surgeon excised the basal cell carcinoma at the same operative session. I had to remove a little devitalized tissue before closing the wound with a full thickness graft. Can I
code both 15260 (full thickness graft) and 11043 (wound debridement)?

**Answer:**
No. The 1104x codes are for debriding an open wound that will heal by secondary intention such as a chronic venous stasis ulcer. You’ll use only 15260 for your reconstructive procedure.

*This response is based on the best information available as of 07/27/17.*

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**Billing for Pre-Op H&P Visit**

July 13, 2017

**Question:**
Hospitals require that we do an H&P within 30 days of taking a patient to the OR. If this visit is more than 48 hours prior to surgery, is that a billable visit?

**Answer:**
No, the H&P in this case is not a billable visit. This question comes up often and was addressed by AMA CPT Assistant in the following excerpt:

“If the decision for surgery occurs the day of or before the major procedure and includes the preoperative evaluation and management (E/M) services, then this visit is separately reportable. Modifier 57, Decision for Surgery, is appended to the E/M code to indicate this is the decision-making service, not the history and physical
(H&P) alone. If the surgeon sees the patient and makes a decision for surgery and then the patient returns for a visit where the intent of the visit is the preoperative H&P, and this service occurs in the interval between the decision-making visit and the day of surgery, regardless of when the visit occurs (1 day, 3 days or 2 weeks) the visit is not separately billable as it is included in the surgical package. Example: The surgeon sees the patient on March 1 and makes a decision for surgery. Surgery is scheduled for April 1. The patient returns to the office on March 27 for the H&P, consent signing, and to ask and clarify additional questions. The visit on March 27 is not billable, as it is the preoperative H&P visit and is included in the surgical package.”

Source: AMA CPT Assistant, May 2008/Volume 19, Issue 5, pp. 9, 11

CPT says once the decision is made to proceed with surgery the subsequent visits related to the procedure (e.g., doing H&P, getting consent form signed, answering questions) are included. However, in some cases a patient may be a candidate for a surgical procedure but has a number of medical issues (such as cardiac disease and asthma) that require a medical evaluation to determine if he/she is healthy enough for surgery. After the patient has had a “medical clearance” he/she returns to you to review the medical doctor’s evaluation and you at that point decide to proceed with surgery. This visit can be billed as an E&M visit as the decision for surgery is just now being made.

*This response is based on the best information available as of 07/13/17.
Facial Nerve Monitoring with Ear Procedures

June 22, 2017

Question:
Can I bill for facial nerve monitoring during a cochlear implant or mastoidectomy procedures?

Answer:
Facial nerve, and any cranial nerve, monitoring is included in the primary procedure code (e.g., cochlear implant, mastoidectomy) for the surgeon and should not be separately reported according to both CPT and Medicare. A completely different provider, other than the surgeon or assistant surgeon or co-surgeon or anesthesiologist, may provide and bill for the monitoring.

*This response is based on the best information available as of 06/22/17.

Tympanoplasty with Middle Ear Exploration

June 8, 2017

Question:
I billed 69631-RT for the transcanal tympanoplasty, 20926-RT for the temporalis fascia harvest, and 69440-RT for the middle ear exploration. Should I have used modifier 59 on 69440 because it didn’t get paid?

**Answer:**
No! You should not have coded 69440 for exploring the same ear on which you did the tympanoplasty. Exploring the middle ear is inherent in 69631 and all tympanoplasty as well as mastoidectomy codes and should not be separately reported with 69440.

*This response is based on the best information available as of 06/08/17.*
accurate to separately code +60512. The reimplantation should be done through a separate surgical approach/incision for +60512.

*This response is based on the best information available as of 05/25/17.*