PRP Injection? How Is It Reported?

December 1, 2016

Question:
How is an injection of PRP reported?

Answer:
Code 0232T, Injection(s) platelet rich plasma, any site, with image guidance, harvesting and preparation when performed, is used to report this procedure. A PRP injection is bundled into tendon sheath, trigger point, and joint injections. It is only reported when it is the only procedure performed. As a Category III code, it is not valued by Medicare (has 0 RVUs assigned), so payment is problematic. Most Medicare carriers do not pay for PRP.

*This response is based on the best information available as of 12/01/16.

Reimbursement: Co-surgery

December 1, 2016

Question:
What is the reimbursement for co-surgery using modifier 62? Is it different for the primary and co-surgeon?

Answer:
For Medicare, co-surgery requires two different specialties
performing separate parts of a single CPT code. Private payers may have different policies regarding the specialties involved. For both surgeons, a 62 modifier is appended to the appropriate CPT code(s). Medicare multiples the allowable fee by 125% and splits the reimbursement exactly in half, resulting in a payment of 62.5% to each surgeon. Both surgeons dictate an operative note describing their work and both have post-operative responsibilities.

*This response is based on the best information available as of 12/01/16.

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Acute Blood Loss Diagnosis Codes

December 1, 2016

**Question:**
Our hospital tells us they are developing guidelines for the application of diagnosis codes for acute blood loss anemia post-operatively. They propose the use of lab values pre- and post-op to allow the hospital coders to assign these codes. Is this correct coding?

**Answer:**
No, this is not an acceptable practice. The official Coding Guidelines state that “abnormal findings (lab, x-ray, pathologic, and other diagnostic results) are not coded unless the physician indicates the clinical significance. This means the provider would need to document that the blood loss was clinically significant, required intervention, abnormal, or a
complication of the procedure to assign a diagnosis indicating any of the preceding circumstances.

*This response is based on the best information available as of 12/01/16.

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**Dialysis Access Creation in Lower Extremity**

December 1, 2016

**Question:**
I created an AV access in the leg. What code do I use for this?

**Answer:**
The CPT codes for AV graft or fistula creation apply to the lower extremity as well as the upper extremity. Take a look at codes 36281-36830 for the most appropriate code for the procedure you performed.

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**WEBINAR ALERT!**
The codes for AV access/dialysis circuit imaging and interventions all change on January 1, 2017. Join Teri Romano for a webinar on these and other new vascular codes on December 14, 2016. Click here for more information and registration.
*This response is based on the best information available as of 12/01/16.*

**Moderate Sedation Coding in 2017**

December 1, 2016

**Question:**
I see there are new moderate sedation codes in the 2017 CPT manual. Why were these changed?

**Answer:**
Moderate sedation codes, 99143-99145 codes have been deleted and replaced by codes, 99151-99157. These are part of a Medicare-initiated revision regarding the use of moderate sedation. All codes that previously included moderate sedation as an inherent part of the codes, such as EGD and colonoscopy, have now been revalued to exclude the sedation. As a result, if you personally supervise moderate sedation, you will now report the sedation separately. Tune in for a webinar on December 15th to hear what prompted that change.

**WEBINAR ALERT:**
For more detailed information about Medicare and private payer billing under these new guidelines, please join Teri Romano for a thirty minute Zipinar on December 15, 2016, focusing on
Global Period for ICP Monitor

December 1, 2016

Question:
I did a consultation on an ICU patient (non-Medicare) and placed an intracranial pressure monitor (ICP) via twist drill on a patient this morning. The global period for the ICP monitor code, 61107, is 90 days so I now can’t bill for any follow-up hospital care. What’s the point – I should just not bill for the ICP monitor placement so I can continue to bill for follow up hospital care.

Answer:
Actually, the postoperative global period for 61107 is not 90 days. Rather, it is 0 days so you may continue to bill your follow up hospital care using a subsequent hospital care code (9923x).

For today’s services you’ll report the consultation code, 9925x, appended with modifier 25 as well as 61107.

*This response is based on the best information available as of 12/01/16.
Bilateral Nasal Vestibular Stenosis/Valve Repair

December 1, 2016

Question:
I’ve been billing 30465 and 30465-50 for bilateral. I’m having a hard time getting paid on the second side (30465-50). Should I use modifier 59 instead of modifier 50?

Answer:
No! CPT guidelines state to use modifier 52 (reduced services) on 30465 if only one side is corrected. Therefore, 30465 implies both sides were surgically corrected and it would be inappropriate to append modifier 50 (bilateral procedure).

*This response is based on the best information available as of 12/01/16.

Trigger Point Injections,
More Than One Muscle

November 17, 2016

Question:
My physician performed two trigger point injections in two different muscles. Would it be appropriate to report code 20552 twice for the two injections?

Answer:
No, code 20552, trigger point injection(s) single or multiple trigger point(s) is for injection of 1 or 2 muscles. If more than 2 muscles are injected only 20553, trigger point injection(s), three or more muscles, is reported.

*This response is based on the best information available as of 11/17/16.

Surgical Modifiers: How Do They Impact Reimbursement?

November 17, 2016

Question:
What reimbursement should we expect when using the global period modifiers 58, 79 and 78?

Answer:
Surgical modifiers are used to indicate that a subsequent procedure was performed during the global period of a prior surgery. Modifiers tell the payer the rationale for allowing
payment for this subsequent procedure. The modifiers and reimbursement impact of each is shown below:

**Modifier 58**: to indicate a second procedure was performed as a staged procedure. Reimbursement should be 100% of the allowable fee.

**Modifier 79**: To indicate an unrelated procedure was performed during the global period of the original procedure. Reimbursement should be 100% of the allowable fee.

**Modifiers 78**: To indicate that a complication of an original procedure was treated by a return to the operating room, catheterization or endoscopy suite. Reimbursement should be at 70-80% of the allowable fee. This reduction reimburses for the intra-operative portion of the procedure only, since the patients pre and post-operative services are paid under the original surgery’s flat fee.

*This response is based on the best information available as of 11/17/16.*

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