Meniscectomy vs. Meniscal Repair

October 22, 2015

Question:
Can you please clarify how to report the following procedure: The surgeon documented medial meniscal repair followed by a medial meniscectomy, both performed in the right leg. There are NCCI edits between the two codes showing 29881 payable and 29882 with a Column 2 edit. Do we code the repair or the meniscectomy since both were performed? The surgeon will be paid more if I report the 29882 if I can only report one code. I am not sure if I can report both codes for the same leg or not?

Answer:
Based on your scenario, both the repair and the meniscectomy were performed in the medial compartment. What is missing in your question is the actual documentation. Based on experience, we assume the surgeon attempted a medial meniscal repair that would not hold and converted to a medial meniscectomy. Both procedures were performed in the same compartment, same knee, making CPT code 29881 the most appropriate code.

*This response is based on the best information available as of 10/22/15.
ICD-10-CM

October 22, 2015

Question:

I don’t understand the 7th character extension. Why don’t all codes get the 7th character extension?

Answer:

Good question! Only certain categories of codes have the 7th character extension requirement. For plastic surgery, the most common categories of codes include injuries (S codes) and other complications such as capsular contractures (T codes). The 7th character of A or B is for an initial encounter and used as long as the patient is receiving active treatment for the condition (e.g., consultation in the ER, surgery). The 7th character for subsequent encounters (e.g., D, G, K) is used when the patient has completed active treatment and is the recovery or healing phase of the injury.

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

Suture Removal

October 16, 2014

Question:

I did not operate on this patient but he ended up in my office for suture removal. Isn’t there a code I can bill for removing sutures when placed by another physician?
Answer:

There is indeed a code for removal of sutures, but only if you do it in under “anesthesia other than local” (CPT 15851, Removal of sutures under anesthesia (other than local), other surgeon). If you are removing the sutures under local or no anesthesia, then the service is included in your E&M code.

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.*
Infected Knee

October 8, 2015

Question:
Will you please direct this question to Mary LeGrand? I was consulted to evaluate a patient to rule out a septic knee. I saw the patient in the morning and aspirated the joint; the fluid was cloudy and sent to pathology. Later that day I was notified of an increased cell count and decided to take the patient to the OR later that day for an arthrotomy with lavage. My coder is telling me that I cannot bill CPT code 20610 with the arthrotomy because of a Medicare payment edit. This makes no sense to me. Can you advise if I am able to report this aspiration or not?

Answer:
Thanks for your inquiry. Yes, the aspiration is reportable with CPT code 20610 as you note. You may also report the arthrotomy with knee lavage; for example, CPT code 27310. Your coder is correct in that an NCCI edit is present between the two codes when performed on the same knee, same session. However, in your scenario, they are performed same day, different sessions. Append a modifier 59 (distinct procedure) to CPT code 20610 to indicate the aspiration occurred at a different session on the same day. If your Medicare carrier has instructed to use the new “X” modifiers instead of modifier 59 to indicate the “separate encounter,” you would report 20610 XE instead of 20610-59.

Your service will be reported one of two ways:
27310
20610-59
Or
Bilateral Diagnosis Coding and Bilateral CPT Coding for Otitis Media

October 8, 2015

Question:

If I use one of the new ICD-10-CM codes for otitis media, do I still need to use the CPT modifier 50 for bilateral procedures when I bill for tympanostomy tube placement (69436)?

Answer:

Good question! Changing diagnosis coding systems from ICD-9-CM to ICD-10-CM does not change anything about CPT coding. The CPT coding system does not change at all with our change to ICD-10-CM for diagnosis coding. So, yes, you will still use modifier 50 or RT/LT or whatever modifiers you were using prior to October 1 to accurately report the bilateral procedure.

*This response is based on the best information available as of 10/08/15.*
Bilateral Diagnosis Coding and Bilateral CPT Coding for Breast Reconstruction

October 8, 2015

Question:
If I use the new ICD-10-CM code for acquired absence of the breast (Z90.13), do I still need to use the CPT modifier 50 for bilateral procedures when I bill for breast reconstruction procedures (e.g., 19357, 19364)?

Answer:
Good question! Changing diagnosis coding systems from ICD-9-CM to ICD-10-CM does not change anything about CPT coding. The CPT coding system does not change at all with our change to ICD-10-CM for diagnosis coding. So, yes, you will still use modifier 50 or RT/LT or whatever modifiers you were using prior to October 1 to accurately report the bilateral procedure.

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

Medicare: Debridement
Question:
We attend courses and receive education from KZA consistently on orthopaedic coding. Our practice recently hired a new billing manager and she states that the information we have been given is incorrect for Medicare related to arthroscopic debridement services. The billing managers external resource told her that 29822 or 29823 can be reported with other arthroscopic shoulder services as long there is no NCCI edit in place. We are telling the new manager that this is incorrect for Medicare.

Can you please help validate what we perceived we heard from KZA is correct? To re-state, our question evolves around reporting debridement services (CPT codes 29822 and 29823) to Medicare when the patient has other arthroscopic shoulder procedures on the same shoulder. We understood, and have told the new billing manager, that the debridement services are considered inclusive to other arthroscopic procedures performed and reported on the same day if the debridement services are performed on the same shoulder. Our manager is telling us that if there is no edit in place, for example with CPT code 29826 and 29822, that we can report both to Medicare. Again, for clarification, she cites a non-KZA resource person.

Answer:
Thanks for your loyalty and reaching out. Based on the information provided, you accurately perceived the instructions for reporting arthroscopic shoulder procedures to Medicare. While there are no NCCI edits between some of the arthroscopic procedures and either CPT code 29822 or 29823, it is considered incorrect coding to report one of these debridement codes in addition to other arthroscopic shoulder procedures performed on the ipsilateral or same shoulder. One
common error in coding according to Column 1 and Column 2 code edits is assuming if there is no edit, that the code combination may be reported together.

The following source information used by KZA in all orthopaedic instructions is found in the January 2015 NCCI Musculoskeletal Chapter 4:
“4. With the exception of the knee joint, arthroscopic debridement should not be reported separately with a surgical arthroscopy procedure when performed on the same joint at the same patient encounter. For knee joint arthroscopic debridement see the following paragraph.”

While a Column 1 or Column 2 edit may not exist in the Excel database, these written guidelines provide additional coding information in addition to the Column 1 and Column 2 edit. CPT codes 29822 or 29823 are not reportable with other arthroscopic shoulder procedures on the same shoulder, same session.
*This response is based on the best information available as of 09/24/15.

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**ICD-10-CM for Otitis Media**

**September 24, 2015**

**Question:**

I am hoping that ICD-10-CM has codes for recurrent acute otitis media since this is one of the most common reasons why we put in tympanostomy tubes. Did this happen?

**Answer:**

Yes – someone must have heard you! Many of the otitis media
codes now specify acute, acute recurrent, and chronic. Laterality is also a prominent issue with the ear codes. For example, serous otitis media has the following specific codes:

H65. 01 Acute serous otitis media (ASOM), right ear  
H65.02 ASOM, left ear  
H65.03 ASOM, bilateral ears  
H65.04 Acute recurrent serous otitis media (ARSOM), right ear  
H65.05 ARSOM, left ear  
H65.06 ARSOM, bilateral ears  
H65.21 Chronic serous otitis media (CSOM), right ear  
H65.22 CSOM, left ear  
H65.32 CSOM, bilateral ears

*This response is based on the best information available as of 09/24/15.

Acellular Dermal Matrix Placement for Breast Reconstruction

September 24, 2015

Question:

I’m doing bilateral tissue expander breast reconstructions and will be using ADM. Is there a separate code for the ADM?

Answer:

Yes, there is. In addition to 19357 (Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion) you can report an add-on code, +15777
(Implantation of biologic implant (e.g., acellular dermal matrix) for soft tissue reinforcement (e.g., breast, trunk))
(List separately in addition to code for primary procedure).
You can report both codes bilaterally, with modifier 50.

*This response is based on the best information available as of 09/24/15.*