Trigger Point Bundling

February 16, 2017

**Question:**
A trigger point injection and a joint injection are bundled by Medicare. Does that mean I can’t bill both if I do both at the same encounter?

**Answer:**
You are correct, trigger point injection (20552 or 20553) and a joint injection, for example, a shoulder joint injection, (20610) are bundled by Medicare. You will note, however, that a modifier is allowed to override this edit. Overriding the edit is appropriate if you are doing the procedures in different anatomic locations. Therefore, doing a trigger point injection in the shoulder along with a shoulder joint injection should not be billed together. A trigger point injection in a different anatomic location, for example the back, would be separately reportable with the appropriate modifier (59 or XS).

*This response is based on the best information available as of 02/16/17.*
Question:
In ICD-9-CM, there was a specific diagnosis code for converting a laparoscopic procedure to open. I can’t find a similar code in ICD-10? What do you suggest? Having a diagnosis code for this can be helpful in justifying a 22 modifier for increased services, especially when I spend significant time in one approach before I have to convert to an open approach.

Answer:
You are correct, under ICD-9 the code, V64.4 Closed surgical procedure converted to open procedure with codes for laparoscopic (V64.41, thoracoscopic (V64.41) and arthroscopic (V64.43) 4 would be used to describe converting to an open procedure. No corollary code existed in ICD-10, 2016 version. But good news! The 2017 version of ICD-10 (effective October 1, 2016 – so right now!) has approximately 2000 new or revised codes and now includes codes for converting to an open procedure. The codes are:

- Z53.31 Laparoscopic procedure converted to open
- Z53.32 Thoracoscopic procedure converted to open
- Z53.33 Arthroscopic procedure converted to open
- Z53.39 Other specific procedure converted to open

Z53.39 would be appropriate for an endovascular procedure converted to an open surgical procedure.

*This response is based on the best information available as of 02/16/17.*
Lip Repair

February 16, 2017

Question:
What is the difference between 40761 and 40527? I’m confused.

Answer:
Here are the code descriptions with the major differences bolded.

40761: Plastic repair of cleft lip/nasal deformity; with cross lip pedicle flap (Abbe-Estlander type), including sectioning and inserting of pedicle.

40527: Excision of lip; full thickness, reconstruction with cross lip flap (Abbe-Estlander). So 40761 is used for only cleft lip/nasal deformity repair while 40527 is used for an excision procedure (e.g., cancer) with reconstruction.

*This response is based on the best information available as of 02/16/17.

Coding With 27193

February 16, 2017

Question:
My coder just said they deleted 27193 and replaced with 2 small no global period codes? Is that correct?
Answer:
They didn’t really replace it with 2 codes, they replaced 27193 with 27197...both codes without manipulation. They replaced 27194 with 27198, both codes with manipulation.

Notice the difference in the language for the non-manipulative treatment:

DELETED: 27193 Closed treatment of pelvic ring fracture, dislocation, diastasis or subluxation without manipulation was replaced with

NEW: 27197 Closed treatment of posterior pelvic ring fracture(s), dislocation(s), and diastasis or subluxation of the ilium, sacroiliac joint, and/or dislocation(s) of the pubic symphysis and/or superior/inferior rami, unilateral or bilateral; without manipulation.

Note that both new codes have 0 global days, a big change for the 90 day global period of the deleted codes. There is also a notation that evaluation and management codes should be used in place of the global code to report the closed treatment of ONLY anterior pelvic ring fracture(s) and or dislocation(s) pubic symphysis and/or superior/inferior rami, unilateral or bilateral; without manipulation.

*This response is based on the best information available as of 02/16/17.

STAY UPDATED WITH KZ ALERTS
ICD-10-CM Coding for Converting to an Open Approach

February 16, 2017

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*This response is based on the best information available as of 02/16/17.*
Lesion Excision

February 16, 2017

**Question:**
How do I code a malignant lesion 1.5 cm on the nose and a 1.5cm malignant lesion on the chest measuring 2.1cm? Do I need a modifier?

**Answer:**
You would report 11642 for the 1.5 cm malignant lesion on the nose and 11603 for the 2.1 cm excision of the chest. You will need to append Modifier 51 to CPT 11642 which is the lower valued procedure (RVU). Do not use Modifier 59 (modifier of last resort) as these two codes are not bundled under the National Correct Coding Initiative (NCCI).

*This response is based on the best information available as of 02/16/17.*

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Removal of Posterior Segmental Instrumentation

February 16, 2017
Question:
We removed posterior instrumentation from L3-L5 and I want to code it as 22852 x 3 units because there are three levels involved. My neurosurgeon doesn’t think that is right. What do you think?

Answer:
Your neurosurgeon is correct – the code is reported once regardless of the number of levels of contiguous levels are involved.

*This response is based on the best information available as of 02/16/17.

Irrigation and Drainage
February 2, 2017

Question:
There is some confusion in my office as what is the difference between a simple and complication irrigation and drainage (I&D) of an abscess. Can you help?

Answer:
A simple I&D includes drainage of the pus or purulence from the cyst or abscess and is reported with CPT 10060. The physician leaves the incision open to drain on its own, allowing for healing with normal wound care. A complex I&D includes placement of a drainage tube to allow for continuous drainage or packing to facilitate healing and reported with CPT 10061. In certain cases, tissue excision, primary closure, and/or Z-plasty may be required. Incision and drainage of a
CPT says that if there is not a code that describes specifically what was performed, you must use an unlisted code.

Since there are no laparoscopic codes for resection of a lesion of the pancreas, you would report 48999, unlisted code, pancreas. For setting a fee, you can compare the work to the most similar open code, 48120-48160. And remember, if a code does not specifically say “laparoscopic” in its description, it is intended as an open code only.

*This response is based on the best information available as of 02/02/17.*
Pain Management

February 2, 2017

Question:
My group has a policy that orthopaedic surgeons deal with patient’s post-operative pain for 6 weeks and then they are referred to the physiatrists in the group to manage all ongoing pain. Can the physiatrist bill for these E/M visits since they are a different specialty even though the patient is in the global period?

Answer:
Post-operative pain management is included in the global for 90 days. If it is the groups policy for a pain physician to see all post-op patients, this will most likely be seen as part of the global package and not separately billable, even though a physician of a different specialty is providing the pain management.

*This response is based on the best information available as of 02/02/17.*