CPT Coding for Converting to an Open approach

March 2, 2017

Question:
My doctor started a laparoscopic cholecystectomy that had to be converted to open due to significant adhesions. He documented both approaches and the laparoscopic approach took significant time before he had to convert to open. Can both be billed?

Answer:
Unfortunately, no. Whenever a “closed” procedure (laparoscopic, arthroscopic, endovascular) is converted to an open procedure only the open procedure may be reported. If a significant amount of time was spent attempting the closed procedure, and this is documented, a 22 modifier for increased procedural services may be appended to the open code. Don’t forget to add the appropriate diagnostic code to indicate the conversion. See the appropriate diagnosis codes below:

- 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

*This response is based on the best information available as of 03/02/17.*
Fluoroscopic Guidance

March 2, 2017

Question:
Can we code for fluoroscopic guidance (77002) for an injection into the hip bursa (20610)?

Answer:
Yes, if imaging guidance is performed you may report 77002 in addition to the injection of the hip bursa. Note that in 2017, 77002 has been revised and I now an add-on code. Directly under the code, CPT lists primary codes that are appropriately coded with 77002. Code 20610 as well as the other joint injection codes (20600 small joints and 20605 intermediate joints) are listed as appropriate primary codes.

*This response is based on the best information available as of 03/02/17.*

Mesh Hernia Reporting

March 2, 2017

Question:
If my surgeon repairs an incarcerated inguinal hernia with mesh on an adult, what code do I use to report the mesh?

Answer:
The mesh is not separately reportable as it is an inherent part of the procedure; it was necessary in order to complete the repair of the hernia. CPT code 49507 would be the CPT code
that would be reported in this case.

*This response is based on the best information available as of 03/02/17.

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**Lesion Excision**

March 2, 2017

**Question:**
My physician removed a malignant lesion 1.0 cm of the scalp three days ago. I billed that procedure with CPT code 11621. Today we received a pathology report which indicated there were still positive margins. Should I use Modifier 59 when report the second lesion excision.

**Answer:**
When the margins are still positive and you re-excise the lesion within the 10-day global period you would report Modifier 58 (staged or related procedure or service during the postoperative period. If the physician waits until after the 10-day global period a modifier would not be appended to the excision code.

*This response is based on the best information available as of 03/02/17.
Billing Medicare Patient Admittance

March 2, 2017

Question:
If a Medicare patient has been admitted to the hospital as an inpatient and the patient is transferred to my care in the ED before they are moved to an inpatient bed, do I bill an ED visit or an initial hospital care code when surgery is not planned?

Answer:
Since the patient has been formally admitted you would report CPT codes 99221-99223 for initial hospital care depending the documentation and medical necessity for the complexity of the patient. Keep in mind Medicare does not pay for inpatient or outpatient consultations.

*This response is based on the best information available as of 03/02/17.

Pap Nap Coding

March 2, 2017

Question:
How would you code for a pap nap?

Answer:
A Pap-nap is an abbreviated sleep study typically used to help
patient adjust to a CPAP and is performed for less than 6-hours during the day. The American Academy of Sleep Medicine recommends providers use CPT code 95807-52. A typical sleep study is 6 or more hours. When the sleep study is less than 6 hours Modifier 52 is reported for reduced services. Some payers do consider a Pap-nap to be investigational and/or a non-covered service and will not reimburse for this service. It is recommended you check with the individual payer before performing the procedure.

*This response is based on the best information available as of 03/02/17.

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**Bilateral Laminectomy**

March 2, 2017

**Question:**
Can we bill 63047 with modifier 50 when we do a bilateral procedure?

**Answer:**
The code descriptor for 63047 is:

Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (eg, spinal or lateral recess stenosis)), single vertebral segment; lumbar

Notice the words “unilateral or bilateral” which means this code includes removal of one or both sides; therefore, it would not be appropriate to append modifier 50 to 63047.
Septal Cartilage Graft and Septoplasty

February 16, 2017

Question:
My doctor did a septoplasty, CPT 30520, removed cartilage and fashioned it for a graft that he used in the surgical repair of vestibular stenosis, CPT 30465. Can we also code 20912 for the fashioning of the graft or just 30520 and 30465? I couldn’t find any CCI edits preventing this.

Answer:
Only one code, 30520 or 20912, may be reported as these procedures were performed through the same incision. What was the reason for the incision – to straighten the septum (30520) or to obtain the graft (20912)? Use whichever code is supported by the documentation but do not use both codes.

*This response is based on the best information available as of 02/16/17.*
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.*
Converting to an Open Approach

February 16, 2017

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.*