ICD-10-CM for Sinusitis

March 16, 2017

Question:
We are having a discussion in the office about the correct way to code chronic sinusitis of multiple sinuses in our office. Some are saying to code each sinus condition separately as they have specific codes for each one, some say to code with the “other code”. Who is correct?

Answer:
Well, it depends on the situation. If a patient has chronic sinusitis of one sinus, then you code the specific chronic sinusitis code from category J32:

- J32.0 Chronic maxillary sinusitis
- J32.1 Chronic frontal sinusitis
- J32.2 Chronic ethmoidal sinusitis
- J32.3 Chronic sphenoidal sinusitis

If the patient has all four sinuses affected (unilaterally or bilaterally), then code J32.4 is reported alone for chronic pansinusitis. If the patient has more than one sinus affected, but not pansinusitis, then code J32.8 is reported instead of each individual code. There is an instructional note under code J32.8 that states it is for use for chronic sinusitis involving more than one sinus but not pansinusitis. The same rules would apply for acute and acute recurrent sinusitis under category J01.

*This response is based on the best information available as of 03/16/17.
Question:
My physician excised a malignant skin lesion from the left cheek measuring 2.0 cm. The defect was repaired with a rotational advancement flap with total primary and secondary defect area of 4.75 sq cm. I submitted my claim with CPT 14040 (advancement flap), 12052-51 (repair), and 11642-51 (malignant lesion excision). My claim was denied. Did I code this correctly?

Answer:
You should have reported one CPT code 14040 for the advancement flap which includes the lesion excision and repair. You should resubmit the claim with CPT 14040 and you should get paid.

*This response is based on the best information available as of 03/16/17.

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Question:
I’m new to neurosurgery coding and notice a big problem with denials. Medicare doesn’t pay us on 20930 and 20936. I’ve been
appealing but don’t seem to have any success. Can you help?

**Answer:**
While CPT says it is accurate to code 20930 (morselized allograft) and 20936 (local autograft), Medicare considers both codes “bundled” into the primary code which is typically an arthrodesis/fusion code. Accept these denials and don’t waste your time appealing denials to Medicare.

*This response is based on the best information available as of 03/16/17.*

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**Scribe Question**

March 16, 2017

**Question:**
In my office, we use a PA as a scribe for new patient office visits for our doctors. We have an electronic medical record and the scribe signs in under her own name when she begins notating for the doctor. What is the correct way to notate in the medical record that the PA is only acting as a scribe and not performing the service personally?

**Answer:**
Good question. In order to clearly indicate what was performed, the documentation must identify who rendered the service and that the PA was acting solely as a scribe and did not perform any of the services. Remember, a scribe does not ask the patient questions or perform any examination of the patient. Both parties need to sign the medical record (electronically will suffice) and attest to the situation.
Noridian, the Jurisdiction E local Medicare contractor, gives the following acceptable attestation example:

“I, _____________, am scribing for, and in the presence of, Dr. __________.” for the scribe; and
“I, Dr. __________, personally performed the services described in this documentation, as scribed by ____________ in my presence, and it is both accurate and complete.” for the physician.

Some payors only require the physician to sign the note as an attestation and not make a separate statement (as in the Noridian example above). You may want to check with your payors to see if they have specific verbiage that they look for to support the use of a scribe.

*This response is based on the best information available as of 03/16/17.

**Modifier 59 or not for Medicare?**

March 16, 2017

**Question:**
I am confused how to submit the following code combination to Medicare. The surgeon documented a right shoulder injection with US guidance (CPT code 20611) and a left knee injection without US guidance (20610). I know the codes are inclusive to each other and want to make sure I submit the claim correctly.
I am sometimes confused when I should use modifier 59 and wonder if this is a situation where the modifier 59 is the most specific modifier.

**Answer:**
You are not alone in being confused about when to use Modifier 59 to Medicare and when another more specific modifier would be appropriate. Let’s take a look at a few modifiers and see if we can narrow the spectrum of options with some rationale.

**Modifier 50 — Bilateral Procedures:** This modifier is not a correct option because the exact same procedure was not performed on the exact contralateral joint.

**Modifier 76 — Repeat Procedures by the Same Physician:** This modifier is not a correct option because the same CPT code is not reported twice (according to Medicare) during the same face-to-face encounter or on the same date.

**Modifier 59 — Distinct Procedures:** This modifier is an option but according to Medicare carriers, there are more specific modifiers that can be used to describe the distinctness of the procedures and avoid the use of modifier 59.

So what modifiers are more specific?
The more specific modifiers are the anatomic modifiers: RT (right) and LT (left). The goal is to avoid using modifier 59 if a more specific modifier exists. In this case, according to Medicare the RT/LT modifiers are more specific and offset the need to use modifier 59.

Report the following CPT codes on the claim form linked to the associated accurate diagnosis:

- 20611 RT linked to a shoulder diagnosis
- 20610 LT linked to a knee diagnosis

This minimizes using modifier 59 to Medicare, and at the same time, accurately reflects the procedures were performed at
different anatomic sites.

NOTE: The anatomic modifiers would have also been the most specific if the two injections had been given to both shoulders; one with US guidance and one without US guidance. The codes would be submitted as follows:

- 20611 RT linked to a shoulder diagnosis
- 20610 LT linked to a shoulder diagnosis

*This response is based on the best information available as of 03/16/17.

Use of Localization Device

March 16, 2017

Question:
If I do a percutaneous biopsy with ultrasound imaging of one lesion, but don't place a localization device, what code should I use?

Answer:
Good question! If you read the description for the code below, 19083, it states” with placement of localization device (s)...., when performed. This distinction means that if you do not place a localization device, this code is still appropriate. Remember to use the add-on code if you biopsy a second lesion/mass.
Cranial Tongs with ACDF

March 2, 2017

Question:
Are we able to report CPT code 20660 for the application of cranial tongs during an anterior cervical discectomy and fusion procedure? The surgeon documented the tongs were applied and removed during the operative case.

Answer:
Thank you for your inquiry. CPT code 20660 is the correct code for the application of cranial tongs. The full definition is “Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure)”. First, in reviewing the code, please note that the code has a ‘separate procedure’ designation. This means that the work associated with this CPT code is an integral part of a more extensive procedure. This means that CPT code 20660 is not reportable with CPT code 22551 “Arthrodesis, anterior interbody, including disc space...
preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical below C2” (aka ACDF) which is reported for the anterior cervical discectomy and fusion code. The use of a tongs or head holders, etc. for intra-operative positioning of the head is inclusive to any spinal procedure.

Additionally, the lay description published in Encoder Pro includes the work of applying skull traction tongs; this inclusion in the description of the procedure and the separate procedure designation preclude the surgeon from reporting CPT code 20660 in addition to the ACDF procedure code.

Typically the codes associated with halo application are reportable when the halo is applied as a stand-alone procedure or the halo is applied for longer term stabilization meaning the patient leaves the operative suite with the halo applied.

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

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.*

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**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.