Augmentation of Pedicle Screws

February 18, 2016

Question:
My neurosurgeon recently went to a meeting where someone told him that they bill a vertebroplasty (22521) for injection of cement around pedicle screws at the time of placement. They said as long as there is a separate diagnosis of osteoporosis then it’s ok. Is this true?

Answer:
No. Augmentation of pedicle screws at the time of placement (e.g., 22840, 22842) is not separately reported and is considered inclusive to the instrumentation code billed.

*This response is based on the best information available as of 02/18/16.

Exchange of Implants After Breast Reconstruction

February 18, 2016

Question:
We have a patient who had bilateral mastectomies and had permanent implants placed several years ago. She now wants smaller implants. I have to get precertification for this procedure and am looking at the CPT codes 19328 (implant removal) and 19325 (breast augmentation) for the procedure. Would that be right?
Answer: 
Actually, it is best to report 19340 (Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction) for this procedure since the patient has had prior mastectomies. Precertification is important as many payers will not pay for the implant exchange without an associated medical condition (e.g., painful capsular contracture).

*This response is based on the best information available as of 02/18/16.

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**ICD 10: Aftercare Z Codes or 7th Character Code?**

*UPDATED*

February 4, 2016

**Question:**
Patient has been seen in office during the global period after a rotator cuff repair for a sprain. No X-rays were taken. Internally we will record 99024. Would we assign Z47.89 or the sprain code to 99024?

**Answer:**
Thanks for your inquiry as your question gives us an opportunity to address documentation requirements and how sprains and strains are delineated in ICD-10-CM.

First, under ICD-10-CM descriptions, an acute injury to the rotator cuff muscle or tendon is described as a “strain”, under the subcategory S46,01-, not as a “sprain.” Although
there is also an ICD code for sprain of the rotator cuff capsule, S43.42-, that is not the structure that typically injured.

If you’ve determined that the problem is an injury, you will look to the S codes; if it is a chronic or recurrent problem, you will look to the M codes.

The ICD-10-CM options for a rotator cuff strain are:
S46.011- Strain of muscle(s) and tendon(s) of the rotator cuff of right shoulder
S46.012- Strain of muscle(s) and tendon(s) of the rotator cuff of left shoulder
S46.019- Strain of muscle(s) and tendon(s) of the rotator cuff of unspecified shoulder

Ideally the physician will document whether the strain affects the right or left shoulder; use of the unspecified code is reserved for cases when the laterality is not described.

If the patient is seen in the global period for the injury, then the 7th character D is applied to indicate routine healing following active treatment of an injury.

If the surgery was done to treat a chronic or degenerative condition coded from the M chapter, you will report Z47.89, Encounter for other orthopedic aftercare, provided the follow-up is uncomplicated.

*This response is based on the best information available as of 02/4/16.
Joint Injection with Trigger Point Injection

February 2, 2016

Question:
If I am performing a joint injection with a trigger point injection in two different anatomic areas, can I get paid for both?

Answer:
Yes, you should get paid for both if in different anatomic areas. Modifier 59 should be used (on the lower valued CPT code) with either a modifier 59 (distinct procedure) or XS (separate structure) to identify the different anatomic area or structure. Don’t forget the J code for the medication in addition to the injection.

*This response is based on the best information available as of 02/2/16.

New IVUS Codes 2016!!

February 2, 2016

Question:
I heard the intravascular ultrasound IVUS codes have been changed for 2016. What specific changes were made?

Answer:
The IVUS codes, 37250 and the add-on code 37251 were deleted and replaced by codes 37252 and the add-on code 37253. The biggest change is that the radiological guidance codes,
previously separately billable, are now bundled. Additionally, the new codes include transducer placement and manipulation and are also included in IVC filter placement/repositioning/removal. CPT guidelines also state that if lesion extends across the margins of one vessel into another, only a single IVUS code is reported, despite imaging more that open vessel.

The new codes are listed below.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>37252</td>
<td>Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation</td>
<td>Replaces 37250</td>
</tr>
<tr>
<td></td>
<td>and/or therapeutic intervention, including radiological supervision and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>interpretation; initial noncoronary vessel</td>
<td></td>
</tr>
<tr>
<td>+37253</td>
<td>Each additional noncoronary vessel</td>
<td>Replaces 37251</td>
</tr>
</tbody>
</table>

*This response is based on the best information available as of 02/2/16.*

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**Repair of Nasal Vestibular Stenosis**

**February 2, 2016**

**Question:**

I am trying to come up with the right CPT codes for this procedure so we can get it precertified. Can you help?

**Answer:**
Yes, you are wise to determine the correct codes for precertification, otherwise the surgery might not be paid if you billed different codes. Look at 30465 – Repair of nasal vestibular stenosis (e.g., spreader grafting, lateral nasal wall reconstruction). You may also report a separate code if you harvest graft material through a separate incision. For example, you may report 20912 (Cartilage graft; nasal septum) if you harvest septal cartilage graft when you have not performed a septoplasty at the same operative session. If you did a septoplasty (30520) and repair of nasal vestibular stenosis (30465) then you may not report 20912 for the septal cartilage graft harvested/obtained from the septoplasty.

*This response is based on the best information available as of 02/2/16.

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**Excision of Skin Lesion**

February 2, 2016

**Question:**
I heard you say at a course (you were great, by the way, I learned a lot from you!) that we should wait for a pathology report before billing for excision of skin lesions. Please explain why. This may be why I’m not getting paid.

Also, when is your next ENT coding course?

**Answer:**
Thank you for your kind words, you made my day! Yes, you’ll need to wait for a pathology report when you report the excision of skin lesion codes because the CPT code descriptions require the pathology be known. The codes are for removal of benign (114xx) and malignant (116xx) lesions.
If you have a previous pathology report showing a malignancy (e.g., biopsy) then you can go ahead and bill the service using the malignant lesion excision code (116xx) without waiting for the pathology report.

Thank you also for asking about our courses. Click here for our ENT Coding courses. I hope to see you soon!

*This response is based on the best information available as of 02/2/16.

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**Scoliosis Screening**

February 2, 2016

**Question:**
How do you report screening for scoliosis when the patient is sent by the school nurse or the pediatrician but, after the examination, there is no scoliosis identified?

**Answer:**
Z13.828 Encounter for screening for other musculoskeletal disorders is used to report this service.

*This response is based on the best information available as of 02/2/16.

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**Separate Procedure. What does**
February 2, 2016

Question:
I noticed that some codes in general surgery have “separate procedure” at the end of the code, for example: 44005, open enterolysis (lysis of adhesions). What does that mean?

Answer:
The “separate procedure” designation means that this procedure is not reported if it is performed at the same time or through the same exposure as a related, more comprehensive procedure. The separate procedure is reported only if it is the only procedure performed or if it is unrelated or distinct from other procedure performed. So if adhesions are lysed as part of a larger procedure, for example a colectomy, only the colectomy is reported.

*This response is based on the best information available as of 02/2/16.

Joint Injections with Ultrasound Guidance

January 14, 2016

Question:
We do a lot of joint injections (20604, 20606 and 20611) and sometimes use ultrasound guidance. Is this bundled with the CPT code or can we get separate reimbursement for the 76942? My doctors think we can get paid for ultrasound separately.
CPT 20604, 20606, and 20611 include ultrasound guidance. 76942 cannot be reported separately. However, if you use Fluoroscopic (77002) guidance, CT (77012) or MRI (77021) you may report these in addition to the injection code for some payers. Keep in mind though, Medicare bundles the imaging with these injections. Don’t forget, the drug injected can be reported in addition to the joint injection procedure.

*This response is based on the best information available as of 01/14/16.