New vs. Established Patient

June 9, 2016

**Question:**
If I see a new patient and during that visit I identify the need for surgery the same day, can I append a Modifier 57 to the E/M service and get paid?

**Answer:**
You determine during the evaluation that the patient would need surgery the same or next day for a major procedure (90 day global), append Modifier 57 to the E/M service. We are seeing denials from various payers when reporting Modifier 57 particularly when the patient is evaluated in the emergency department. You may need to appeal any claim denials as CPT guidelines allow the use of Modifier 57.

If the procedure is a minor procedure with at 10 day global and the E/M service is significantly separately identifiable, report the E/M service with Modifier 25.

Use caution when appending the 25 Modifier as CMS has indicated that there is an inherent E/M service in every procedure and routine use of Modifier 25 may create payer scrutiny.

*This response is based on the best information available as of 06/09/16.*

AVM Embolization

June 9, 2016
Question:
We’ve been told by our outsourced coding company to use 61710 for catheter-based embolization of an AVM. Is that right?

Answer:
Actually, 61710 is a craniotomy code and not one used for transcatheater procedures. You’ll use 61624 as the primary procedure code for transcatheter embolization of an arteriovenous malformation (AVM).

*This response is based on the best information available as of 06/09/16.

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Bilateral Procedures

June 9, 2016

Question:
Our current billing service is using the 50 modifier when we indicate that it is a bilateral procedure for tubes and sinus procedures. However, they are doubling the amount charged when billing for tubes (69436-50) but not for the sinuses. Can you advise me of the proper way for this to be billed?

Answer:
Anytime bilateral procedures are reported on one line (e.g., 69436-50 or 31256-50) the usual fee for the single procedure should be doubled. When the code is billed on two lines (e.g., 69436 then 69436-50 OR 31256 and 31256-50) the single fee is billed twice which equals the double fee. It is not consistent that the billing service would double the fee for tubes but not for other procedures billed bilaterally. This is inconsistent billing and is under-reporting your total charges.
Joint Injections

June 9, 2016

Question:
When my PA performs joint injections, can we report those services under the incident-to billing rules?

Answer:
If the PA scope of practice regulations in your state allow PAs to perform joint injections, the determining factor is whether the incident-to billing rules are met. If you previously set the plan of care for joint injections, they could be reported as incident-to. If the PA made the decision to perform the injection independently, it should be reported as a direct service.

*This response is based on the best information available as of 06/09/16.

Sacral Nerve Destruction

May 26, 2016

Question:
My physician performed sacral nerve destruction of the S1, S2, S3 and S4 peripheral nerves. How do I code this?
Each individual peripheral neurolytic block would be reported with code 64640, Destruction by neurolytic agent, peripheral nerve or branch; coding would be 64640 x 4 units.

*This response is based on the best information available as of 05/26/16.

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**Neuroendovascular Procedure Coding**

May 26, 2016

**Question:**
We are hiring a neurosurgeon who also does neuroendovascular procedures. We’ve never had to code for neuroendovascular procedures before – HELP!

**Answer:**
Oh, that’s great! We think it is fun to learn something new! Here are the principles of neuroendovascular procedure coding – there are 4 types of codes: 1) diagnostic (e.g., angiogram), 2) interventional (e.g., aneurysm coiling), 3) catheterization (e.g., selective catheterization of the T2 spinal arteries), and 4) radiologic supervision and interpretation (e.g., 7xxxx codes). The key is knowing when to use which type of code and understand the necessary documentation. We offer a coding course specifically for neuroendovascular procedures. Please [click here](#) to contact us for more information. There are also some previously asked Q&As as well as a webinar on our website that might help you. You can access the [Coding Update for Neurosurgery here](#). Good luck!
Approach to Pituitary Tumor

May 26, 2016

Question:
I am with Otolaryngology and one of our Physicians has done a case with a Neurosurgeon. I need some advice regarding coding. They did a transsphenoidal pituitary tumor together where our physician opened and assisted the neurosurgeon. The neurosurgeon did 61548 and our physician said he did 30520, 31287-50, 31240-LT, and 30930. Please advise on the best way to bill.

Answer:
The approach (including septoplasty, sphenoidotomy, etc.) to the pituitary tumor and the tumor resection is included in 61548. When ENT does the approach and neurosurgery takes out the tumor, this is considered co-surgery and both surgeons report the same CPT code (61548) with modifier 62 (two surgeons). Therefore, the best way to code the procedure is for each surgeon to report 61548-62. It would be considered “unbundling” to report separate codes for the approach including the septoplasty and sinus surgery. If the procedure is performed endoscopically, then both surgeons report 62165-62.

*This response is based on the best information available as of 05/26/16.*
Using Modifier 57

May 26, 2016

Question:
I saw a patient on a Friday and scheduled surgery for that Monday. Do I need a 57 modifier on the E/M I did on Friday?

Answer:
No. The 57 modifier is required on an E/M code that is the decision for surgery visit if it occurs the day of or the day before the surgery. It is this time period in which an E/M is bundled with a major procedure (one which has a 90 day global period). The day before and the day of a major procedure, an E/M is included in the per-operative portion of the global package unless it is the visit in which the decision for surgery is made.

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New vs. Established Patient

May 26, 2016

Question:
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If the procedure is a minor procedure with at 10 day global and the E/M service is **significantly separately identifiable**, report the E/M service with Modifier 25.

Use caution when appending the 25 Modifier as CMS has indicated that there is an inherent E/M service in every procedure and routine use of Modifier 25 may create payer scrutiny.

*This response is based on the best information available as of 05/26/16.*

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**Sliding Hiatal Hernia**

May 26, 2016

**Question:**
How do I code for an open repair of a sliding hiatal hernia?

**Answer:**
Per CPT, report code 43327 for an open repair of a sliding hiatal hernia via a laparotomy approach and 43328 for the repair via a thoracotomy approach. For more detailed information about hiatal hernias; laparoscopic approaches, coding with bariatric surgery, and more, sign up for an upcoming ACS course in Nashville, Dallas or Chicago. [Click here](#) or contact 312-642-5616 for more information.
*This response is based on the best information available as of 05/26/16.*