Cast Changes During the Global Period

July 30, 2015

Question:
We have not been billing for cast changes during the global period, but have recently been told we should be reporting this service. In our orthopedic physician practice, on occasion a patient will require a cast change (for various reasons). If the physician orders the cast change and is present in the office during the cast change by our cast technician, can we bill Medicare during the 90-day global period?

Answer:
Thanks for your specific question and recognition that Incident-To rules apply in your scenario. Yes, if the physician orders the cast re-application and is in the office while the technician applies the cast, the service is billable to Medicare. Append modifier 58 to the cast application code since the patient is in a global period. Supplies are also reportable assuming the practice incurs the expense.

Lipoma Removal

July 30, 2015

Question:
I removed a huge lipoma from a patient and it seems like the benign skin lesion removal codes just don’t describe what I’m doing. Is there another code I can use?
Answer:

Yes! The “soft tissue tumor” codes were introduced into CPT in 2010 and better describe the procedure you are performing. These codes are located in the Musculoskeletal System section of CPT (e.g., 21555, 21556) rather than in the Integumentary System section of CPT (114xx for excision of benign skin lesions, 116xx for excision of malignant skin lesions).

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Tumor Embolization

July 16, 2015

Question:

I embolized a neck tumor through two separate arteries (the right inferior thyroid artery as well as the left inferior thyroid artery). Do I code 61626 once or twice? Also, I performed follow-up angiography twice so can I bill 75898-26 x 2 or just once?

Answer:

Good questions! CPT 61626 is reported once in your situation because there was only one tumor, or surgical site. As for the follow-up angiography, CPT guidelines allow reporting 75898 per follow-up angiography performed and documented so you may bill it twice. That said, some payers, including Medicare, allow payment of only one unit.

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**Embolizing the Internal Iliac During an EVAR**

Question:

During an EVAR I embolized the internal iliac. Can I code separately for that?

Answer:

Yes. The internal iliac is outside the target zone of the endograft, so an intervention in that vessel may be reported separately. You would bill 37242-59 for the embolization. If
the catheterization of the internal iliac is also documented, report 36246 for the second order catheterization. Remember, if you catheterized the aorta with bilateral catheters (36200-50) one of those non-selective catheter placements will now be bundled into the selective catheterization, 36246.

New or Established Patient Visit?

July 16, 2015

Question:
If a patient presents as a new patient visit and the surgeon reports an injection only, can the surgeon report a new patient visit when the patient returns for the follow up visit?

Answer:
No, the surgeon had a face-to-face encounter with the patient to perform the injection; thus, the follow up visit within the three year period is an established patient visit.

Diagnosis Code

July 16, 2015

Question:
I do a lot of reconstruction procedures after the Mohs surgeon has removed the skin cancer. I am not removing cancer so it
doesn’t seem right to use a cancer diagnosis code. But what diagnosis code should I use?

Answer:

We recommend using an “open wound” diagnosis code since the purpose of your procedure is to close an open wound. You can use the cancer diagnosis code as a secondary diagnosis code.

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**Getting Ready for ICD-10-CM**

July 2, 2015

Dear friends,
In an effort to help you get ready for ICD-10-CM implementation on October 1, 2015, we will answer some diagnosis coding questions in future editions of the Coding Coach. Watch our ICD-10-CM webinars, such as Teri Romano’s upcoming “ICD-10 Training for Non-Traumatic Spine Disorders: Disc, Stenosis, and More!!” on July 7th.

Question:

How do you code lumbar spinal stenosis with radiculopathy?

Answer:

Good question because some spine conditions have a combination code that addresses both problems such as M50.12 for a C4-C5 herniated disc with radiculopathy. However, there is no such combination code for spinal stenosis with radiculopathy. Therefore, you’d use the individual lumbar stenosis code (M48.06) and the lumbar radiculopathy code (M54.16).

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Revisions of Upper Arm Bypass

Question:

How do I report a revision of an upper arm bypass?

Answer:

Unfortunately, there is no CPT code for an upper arm bypass revision. An unlisted code is used for this procedure. To set your fee, use the lower extremity revision code for comparison purposes.