Split Thickness Skin Graft

12/03/15

Question:

Please resolve an internal debate we’re having in our office. Are the STSG codes chosen based on the recipient or the donor site?

Answer:

Good question, and this is always confusing. CPT says: “Select the appropriate code from 15040-15261 based upon type of autograft and location and size of the defect. The measurements apply to the size of the recipient area.” So you’ll choose the code based on the recipient/defect site and the area (in square centimeters) is of that same site. The two STSG graft codes are 15100 (recipient/defect site is trunk, arms or legs) and 15120 (recipient/defect site is face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits).

*This response is based on the best information available as of 12/03/15.*

Endoscopic Skull Base Surgery

12/03/15

Question:

We are thinking about starting an endoscopic skull base
surgery program and doing skull base procedures via an expanded endonasal/endoscopic approach. I’ve looked in the CPT book for codes and it looks like CPT 61580-61619 are just what I’m looking for. Is this correct?

**Answer:**

That’s great that you’re starting a new program! And, we can help. There is one CPT code for an endoscopic skull base procedure – 62165, Neuroendoscopy, intracranial; with excision of pituitary tumor, transnasal or trans-sphenoidal approach. However, other procedures that you’ll do such as an endoscopic resection of a clival chordoma are not accurately coded using 61580-61619, as these existing codes are for open procedures. We wrote an article for the AAO-HNS Bulletin about this a few years ago that I think you’ll find helpful. Here are the links:

- [Sample Prior Authorization, Cover Letter, or Appeal Letter for the Otolaryngologist’s Use of an Unlisted CPT Code for Endoscopic/Endonasal Skull Base Surgery](#)
- [Coding and Reimbursement Strategies: Using an Unlisted Code for Endoscopic Skull Base Surgery](#)

*This response is based on the best information available as of 12/03/15.*

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**Therapy Services**

12/03/15

**Question:**

We have a massage therapist employed in our office who is
being supervised by our physical therapist. Our question: when we bill to Medicare, does the supervising therapist have to sign the massage therapist’s notes agreeing with the care provided that day and the plan of care?

Answer:

Therapy services performed by a massage therapist are not reportable by the therapist “Incident-To”. A therapist may supervise a PTA for Medicare and bill if all rules are met; a massage therapist does not meet the qualified provider rules for therapy according to Medicare.

*This response is based on the best information available as of 12/03/15.

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**Removal of Spinal Cord Stimulator**

12/03/15

**Question:**

My doc removed an electrode plate previously placed via laminectomy – 63662. At the same time, he removed the pulse generator – 63688. Is the removal of the generator considered a secondary procedure and therefore reduced in reimbursement by 50%?

**Answer:**

Yes, that’s correct. CPT 63662 is the higher valued code so it should be paid at 100% of the payer allowable. The generator removal, 63688, is the lower valued code and CPT says to
report it with modifier 51 (multiple procedures).

Therefore, 63688 will typically be reduced by the payer’s multiple procedure payment formula (MPPF). Medicare’s MPPF is 50% for secondary stand-alone procedures.

*This response is based on the best information available as of 12/03/15.

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**Coding Incomplete Colonoscopies**

December 3, 2015

**Question:**

Which code would be appropriate to report 45330, Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure) or 45378, Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure), if the physician is unable to advance the colonoscope to the cecum?

**Answer:**

Per CPT guidelines, if the colonoscopy was a screening or diagnostic colonoscopy, CPT code 45378 would be reported with modifier 53, Discontinued Procedure. This indicates that a diagnostic or screening was not complete to the cecum. If the colonoscope does not reach the splenic flexure, a sigmoidoscopy, code 45330, would be reported.

If the colonoscopy was therapeutic and it is not complete to
the cecum, the appropriate therapeutic colonoscopy code is reported with a 52 modifier.

Refer to the decision tree in the CPT Professional codebook.

*This response is based on the best information available as of 12/03/15.

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**Harvest of Abdominal Fat Graft**

November 5, 2015

**Question:**

My doctor harvested abdominal fat that he then used in the nose to close the area when he did an endoscopic removal of a pituitary tumor (62165). I want to bill 15770, but my doctor thinks the correct code is 20926. What do you recommend?

**Answer:**

Your doctor is correct with 20926 (Tissue grafts, other (e.g., paratenon, fat, dermis)). CPT 15770 (Graft; derma-fat-fascia) is used for a composite graft when more than one layer of tissue is harvested and placed (e.g., fat and fascia). When only one layer of tissue is harvested, such as fat, then report 20926.

*This response is based on the best information available as of 11/05/15.*
Incident-To or Not?

November 5, 2015

**Question:**
A physician assistant sees a Medicare patient in the emergency room independently. Can this visit be billed under the name and NPI of her supervising physician who did not see the patient?

**Answer:**
No, Incident-To services do not apply to hospital-based services, nor do they apply to new patients or patients with new problems. This service must be reported under the NPI of the physician assistant who performed the service in the emergency room.

*This response is based on the best information available as of 11/05/15.

Cerumen Removal....Again

November 5, 2015

**Question:**
I just wanted to verify the guidelines for billing cerumen removal (69210). Before, it needed to state that the cerumen was “impacted” to be able to bill CPT 69210. I was just told that guideline has changed and that anything that goes in the body (I’m thinking like a curette to remove cerumen), even if it is not impacted, is now billable. Is this correct?

**Answer:**
That is incorrect information – the guideline has not changed in that regard. The cerumen must be impacted to report 69210 (Removal impacted cerumen requiring instrumentation, unilateral). What did change a few years ago is the added requirement that instrumentation must be used to remove the impacted cerumen. So, there must be documentation of using a curette, forceps, suction, etc. in the procedure note. Click here for one hour webinar on Resolving the Cerumen Coding Chaos!

*This response is based on the best information available as of 11/05/15.

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**ICD-10-CM: Bilateral Procedures**

November 5, 2015

Question:

Since the new diagnosis codes for absence of the breast includes one specifically for bilateral, will modifier 50 (bilateral procedure) still be required on the CPT code? For example, for bilateral breast reconstruction with a tissue expander and biologic implant, we will use Z90.13 for acquired absence of bilateral breasts and nipples for the diagnosis code. Will we still need modifier 50 on the CPT codes 19357 and 15777?

Answer:

YES! Nothing changes with CPT coding with the implementation of the new diagnosis coding system, ICD-10-CM. So in your example, you’d use 19357-50 and 15777-50 (or 19357, 19357-50,
15777, 15777-50 if the payer prefers each code be listed separately). Click here to see our newly released webinar for everything you ever wanted to know about ICD-10-CM Coding for Plastic Surgery!

*This response is based on the best information available as of 11/05/15.

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+22851 vs. +20931

October 22, 2015

Question:

We’ve been told we cannot bill +22851 and +20931 with the ACDF code, 22551. Is this true?

Answer:

It is true if you are thinking about reporting +22851 (intervertebral device) and +20931 (structural allograft) at the same spinal level. For example, you would not use a PEEK device (+22851) and a structural allograft (+20931) in the same interspace such as at C5-C6. Rather, you would use one or the other.

However, if different products are used at different levels, then it is acceptable to report both codes. For example, a PEEK device is placed at C5-C6 while a structural allograft is placed at C6-C7.

*This response is based on the best information available as of 10/22/15.