**Excisional Biopsy**

January 19, 2017

**Question:**
My doctor’s documentation for a biopsy indicates he performed an “excisional biopsy of the skin”. Is this correct?

**Answer:**
No, CPT does not have a code for excisional biopsy. It is either a biopsy (11100 or 11101) or a benign or malignant excision code. (114xx, 116xx). It is important to use the appropriate terminology in the documentation to make it clear what type of procedure is performed. It is important to remember that all excision codes include a biopsy.

*This response is based on the best information available as of 01/19/17.*

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**Reimbursement: Assistant Surgeon**

January 5, 2017

**Question:**
What is the reimbursement for an assistant surgeon using modifier 80? Is the payment different for the primary and the assistant?

**Answer:**
Assistant surgeon is described as one surgeon, of the same or
a different specialty, providing assistance during a surgical procedure or CPT code. Modifier 80 (modifier 82 for an assistant surgeon in an academic setting when a qualified resident is not available) is appended to any CPT code the assistant participates in. Medicare reimburses 16% of the allowable for the assistant surgeon (modifier 80 or 82), to the codes where an assistant payment is allowed, and multiple procedure/bilateral procedure reductions also apply. The primary surgeon’s fee is not affected. In an assistant surgeon scenario, the assistant need not and should not dictate a separate note. However, it is critical that the primary surgeon document in his/her note, specifically what the assistant did. Stating an assistant was needed because the case was complex is not sufficient. The primary surgeon must state what the assistant did, for example, assisting with the resection, anastomosis, etc. For private payers, coding guidelines and payment may vary.

*This response is based on the best information available as of 01/05/17.

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**Intralesional Injections**

January 5, 2017

**Question:**
Can I Report CPT 11900 x 1 and 11901 for each additional injections for multiple nodular lesions?

**Answer:**
No. CPT 11900 and 11901 are used to report number of lesions, not number of injections. You would report 11900 for up to and
including 7 lesions and 11901 if there are more than 7 lesions. Make sure you document the type of lesions injected (cystic, nodular, keloid, psoriasis, acne, etc.) and location of each individual lesion. You may also separately bill for the medication using an appropriate J code.

*This response is based on the best information available as of 01/05/17.

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**Replacement Code for “Interbody Cage for Disc”**

January 5, 2017

**Question:**
I see that CPT code 22851 – Application of intervertebral biomechanical device(s) to vertebral defect or interspace was deleted in 2017. What code do I use in 2017 for placement of an interbody cage for disc that does not have integral fixation and is being used for fusion? I see the new codes 22853 and 22854 both say with integral anterior instrumentation device for anchoring.

**Answer:**
Three codes have been added to CPT 2017:

- 22853 is used for interbody device insertion, with fusion, with or without integrated anterior fixation
- 22854 is used for interbody device insertion for corpectomy, with fusion, with or without integrated anterior fixation
- 22859 is used for interbody device insertion without fusion

Your options will be 22853 or 22854, depending on whether performing corpectomy. 22853 and 22854 both say “with integral anterior instrumentation for device anchoring when performed.” If you do not use integrated fixation, it is still the same codes. If you use a separate plate, that would be reportable when specific criteria are met (e.g. the plate crosses the interspace, can provide independent stabilization, and can be used with any other type of interspace device.)

To learn everything you need to know about the NEW 2017 CPT codes for spine surgery [click here](#).

*This response is based on the best information available as of 01/05/17.*

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**New Spinal Cage Codes – 2017**

January 5, 2017

**Question:**
I see that CPT code +22851, Application of intervertebral biomechanical device(s) to vertebral defect or interspace was deleted effective 1/1/17. What code do I now use?

**Answer:**
Three codes have been added to CPT 2017 to replace +22851:

- +22853 is used for a device, with fusion, with or
without integrated anterior fixation
  ▪ +22854 is used for a device to fill a corpectomy defect, with fusion, with or without integrated anterior fixation
  ▪ +22859 is used for interbody device insertion without fusion

Note that +22853 and +22854 include the integral anterior instrumentation for device anchoring when that type of device is used. If you do not use integrated fixation, it is still the same codes, +22853 or +22854. If you use a separate plate, you may separately report a code such as +22845 when the plate meets the code criteria (e.g., the plate crosses the interspace, can provide independent stabilization, and can be used with any other type of interspace device).

To learn everything you need to know about the NEW 2017 CPT codes for spine surgery [click here].

*This response is based on the best information available as of 01/05/17.

Myringotomy and Tube – Same Ear

January 5, 2017

Question:
Can we bill myringotomy 69421 and tube 69436 in the same ear? My doctor says no but I don’t see why not.

Answer:
We agree with your doctor. The myringotomy is required in order to place the tube; therefore, 69421 is considered an integral component of 69436 and should not be separately reported when performed in the same ear.

*This response is based on the best information available as of 01/05/17.

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**E/M Guidelines: How Many Elements Make a Comprehensive Exam?**

January 5, 2017

**Question:**
I have a question after a recent coding/billing seminar with Teri Romano (which was excellent!). I use the 1997 Physical Exam Rules and am trying to figure out the required elements for a comprehensive exam. Most information says you need 2 bullets from each of 9 organ systems. While this is easy to understand, I noticed the guidelines also says:

Perform all elements identified by a bullet in at least nine organ systems or body areas and document at least 2 elements identified by a bullet from each of nine areas/systems.

I don’t understand the part underlined above. Can you please explain this? Thank you.

**Answer:**
There are 15 organ systems or body areas listed in the 1997
Exam (pages 82-83); eye, neck, respiratory, cardiovascular, etc. You need to document at least 2 in nine of the system/body areas. Technically, the rule states that you must perform (exam) all but you only need to document 2. You will document the two in each system that you examined for a medically necessary reason. In the event of an internal or external audit, the reviewer will “count” the number of elements you documented. A comprehensive exam is justified if you document 2 in at least 9 system/body areas (18 total).

If your exam typically addresses organ systems, for example, cardiovascular, skin, respiratory, musculoskeletal, etc., you would do better to use the 1995 Exam. If you document that you examined at least one element in each of eight organ systems, it justifies a comprehensive exam.

*This response is based on the best information available as of 01/05/17.*

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**Cosmetic Closure After Spine Surgery**

January 5, 2017

**Question:**
My friend the spine surgeon asked for my help on an upcoming case. It is a two-level anterior cervical discectomy and fusion where the patient requested a plastic surgeon to make the incision and do a cosmetic closure. I checked with his billing office and the codes for the case are 22551, +22552, +22845, and +20931. Am I a co-surgeon (modifier 62) on all the
same codes because I’m doing the incision and closure?

Answer:
Actually, you should not bill anything to insurance. The incision and usual closure are included in the primary procedure code, 22551. If the patient wants a “cosmetic” result then this is cash from the patient and it should not be billed to insurance.

*This response is based on the best information available as of 01/05/17.

An Office Visit and an Injection. Can I Bill Both with a Modifier 25?

January 5, 2017

Question:
A colleague informed me that billing an office visit every time I give a patient an injection can lead to an audit. I also read a recent article where an orthopedic practice had to pay back millions of dollars partially for this reason. I typically bill an established patient visit with an injection, but I always add a 25 modifier to the visit. Does that mean I am safe from an audit?

Answer:
Unfortunately, no. It is true that an evaluation and
management code, an E/M or office visit, can be reported with a minor procedure such as an injection, but only if the E/M is significant and separate and exceeds the “pre-service evaluation” that is inherent to the injection. Every minor procedure has time for pre-service evaluation included in the value of the procedure code. Medicare and other payors have become concerned that E/M’s are being routinely reported with minor procedures without considering if the extent of the visit was truly more than the pre-service evaluation already included in the procedure.

To hear more about how to determine when a visit is “significant and separate” and how to document that “pre-service evaluation” has been exceeded, join Teri Romano for a webinar on January 9, 2017.

*This response is based on the best information available as of 01/05/17.

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**Reporting Symptoms**

December 15, 2016

**Question:**
If a patient presents with MRI findings confirming a traumatic right ACL tear (sprain) S83.511A, should we report additional codes to describe the symptoms knee pain, swelling, or difficulty walking?

**Answer:**
No, signs and symptoms that are associated routinely with a disease or injury should not be assigned additional codes
unless you are instructed to do so by the classification.

*This response is based on the best information available as of 12/15/16.