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.
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!
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.
+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.

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Meniscectomy vs. Meniscal Repair

October 22, 2015
**Question:**
Can you please clarify how to report the following procedure: The surgeon documented medial meniscal repair followed by a medial meniscectomy, both performed in the right leg. There are NCCI edits between the two codes showing 29881 payable and 29882 with a Column 2 edit. Do we code the repair or the meniscectomy since both were performed? The surgeon will be paid more if I report the 29882 if I can only report one code. I am not sure if I can report both codes for the same leg or not?

**Answer:**
Based on your scenario, both the repair and the meniscectomy were performed in the medial compartment. What is missing in your question is the actual documentation. Based on experience, we assume the surgeon attempted a medial meniscal repair that would not hold and converted to a medial meniscectomy. Both procedures were performed in the same compartment, same knee, making CPT code 29881 the most appropriate code.

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

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**7th Character Extension in ICD-10-CM**

October 22, 2015

**Question:**
I don’t understand the 7th character extension. Why don’t all codes get the 7th character extension?
Answer:

Good question! Only certain categories of codes have the 7th character extension requirement. For plastic surgery, the most common categories of codes include injuries (S codes) and other complications such as capsular contractures (T codes). The 7th character of A or B is for an initial encounter and used as long as the patient is receiving active treatment for the condition (e.g., consultation in the ER, surgery). The 7th character for subsequent encounters (e.g., D, G, K) is used when the patient has completed active treatment and is in the recovery or healing phase of the injury.

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

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**Suture Removal**

October 16, 2014

Question:

I did not operate on this patient but he ended up in my office for suture removal. Isn’t there a code I can bill for removing sutures when placed by another physician?

Answer:

There is indeed a code for removal of sutures, but only if you do it in under “anesthesia other than local” (CPT 15851, Removal of sutures under anesthesia (other than local), other surgeon). If you are removing the sutures under local or no anesthesia, then the service is included in your E&M code.
1997 CMS Neurological Exam

October 8, 2015

Question:

Please explain the difference between the Eyes exam bullet and the bullet for the exam of cranial nerves 3, 4 and 6.

Answer:

The exam element for the Eyes states “Ophthalmoscopic examination of optic discs (e.g., size, C/D ratio, appearance) and posterior segments (e.g., vessel changes, exudates, hemorrhages).” This requires use of an ophthalmoscope and examination of the posterior segments including the optic discs.

Exam of cranial nerves 3, 4 and 6 does not require the use of an ophthalmoscope. Rather, the neurosurgeon observes eye movements and the pupils to determine cranial nerve function.

*This response is based on the best information available as of 10/08/15.*