Code 37202 – Deleted!

April 14, 2016

Question:
What happened to code 37202 for non-thrombolytic infusions?

Answer:
The code for transcatheter therapy, infusion other than thrombolysis; any type (37202) has been deleted, along with its paired radiological supervision and interpretation code for guidance (75896). Peripheral injection of a non-thrombolytic drug, verapamil for example, is considered inclusive to the primary procedure. A replacement code for 37202 was developed but it now applies only to intracranial infusions.

*This response is based on the best information available as of 04/14/16.

Source for a Consult

April 14, 2016

Question:
What is an appropriate “source” for a consult? I asked at a recent workshop and the instructor did not have an answer.

Answer:
CPT guidelines state that a consultation must be requested by a physician or "other appropriate source". CPT defines other appropriate source as a physician assistant, nurse practitioner, doctor of chiropractic, physical therapist, occupational therapist, speech language therapist,
psychologist, social worker, lawyer, or insurance company. Do not report a consultation requested by a patient or family member, etc., using a consultation code. Remember that Medicare no longer recognizes the consultation codes for payment. Some private payers continue to pay for consultations but this will vary by payer. The definition of “other appropriate source” may also vary by payer. Bottom line? Know your individual payer policies.

*This response is based on the best information available as of 04/14/16.

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New or Existing Patient Coding

April 14, 2016

Question:
If I see a new patient (9920x) for a spine problem, then they come back to me for carpal tunnel syndrome two months later, can I bill as a new patient visit (9920x) the second time or is it an established patient to me (9921x)?

Answer:
No, this would be an established patient (99211-99215). If you or another neurosurgeon in the same group practice treat the patient in the past three years (face-to-face), the patient visit would be coded as an established patient even if you are evaluating a new problem. By CPT definition, “a new patient is one who has not received any face-to-face professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years.” An established patient is one who has
received professional services (face-to-face) from the physician or another physician in the same group and the same specialty within the prior three years. Unfortunately, payers do not recognize the different subspecialties of neurosurgery.

*This response is based on the best information available as of 04/14/16.

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**Placement of Doyle Splints**

April 14, 2016

**Question:**
My doctor documents placement of Doyle splints in the nose which are sutured to the anterior septum after a septoplasty. Can I bill 31299 for this?

**Answer:**
No, placement of intranasal splints, dressings and packing is part of the wound closure and not separately reported.

*This response is based on the best information available as of 04/14/16.

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**Scoliosis Screening**

April 14, 2016

**Question:**
How do you report screening for scoliosis when the patient is sent by the school nurse or the pediatrician but, after the
examination, there is no scoliosis identified?

Answer:
Z13.828 Encounter for screening for other musculoskeletal disorders is used to report this service.

*This response is based on the best information available as of 04/14/16.

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Source for a Consult

March 31, 2016

Question:
What is an appropriate “source” for a consult? I asked at a recent workshop and the instructors did not have an answer.

Answer:
The guidelines for a consultation (inpatient or outpatient) must be requested by a physician, or qualified non-physician practitioner. Guidelines are not clear regarding individuals who may be considered an appropriate source, but some likely examples include a physician assistant, nurse practitioner, doctor of chiropractic, physical therapist, occupational therapist, speech language therapist, psychologist, social worker, lawyer, or insurance company. Do not report a consultation requested by a patient or family member, etc., using a consultation code.

*This response is based on the best information available as of 03/31/16.
New or Existing Patient Coding

March 31, 2016

Question:
If I see a new patient for a general plastics issue, then they come back to me for a hand issue two months later, can I bill as a new patient visit the second time?

Answer:
No, this would be an established patient (99211-99215).

If you or another plastic surgeon in the same group practice treat the patient in the past three years (face-to-face), the patient visit would be coded as an established patient even if you are evaluating a new problem.

By CPT definition, “a new patient is one who has not received any face-to-face professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years.”

An established patient is one who has received professional services (face-to-face) from the physician or another physician in the same group and the same specialty within the prior three years.

This rule applies to Office or Other Outpatient services, but does not apply to Outpatient or Inpatient Consultations or Initial Hospital or Subsequent Hospital Care services.

*This response is based on the best information available as of 03/31/16.
Revising an Upper Extremity Bypass

March 31, 2016

Question:
What codes are used for revision of an upper extremity bypass graft?

Answer:
Use an unlisted code as there are no existing CPT codes for revision of an upper extremity bypass graft.

*This response is based on the best information available as of 03/31/16.

Minor vs. Major Procedure

March 31, 2016

Question:
What is the difference between a minor and major procedure?

Answer:
A minor procedure is defined as one with a zero or 10 day global period. For example, debridement has a zero day global period, and excision of a benign skin lesion has a 10 day global period. A major procedure is defined as one with a 90 day global period. Most open surgical procedures have a 90 day global period. Procedures are paid a global “flat fee” and E/M visits and other procedures directly related to the original procedure during the global period are considered inclusive to that procedure and not separately reported/billed. Exceptions
occur and modifiers are used to describe these exceptions and allow payment. For example, you perform an unrelated procedure during the global period or one that is staged from the first. Refer to the modifier section of the CPT manual for descriptions of modifiers and attend a KZA Coding workshop to learn how to accurately use modifiers specific to your specialty.

*This response is based on the best information available as of 03/31/16.

Intraoperative Ultrasound

March 31, 2016

Question:
We used an outside coding consulting company (not yours!) to review some notes. They told us we could bill 76998-26 for intraoperative ultrasound when we also bill for a brain tumor removal (e.g., 61510, 61512). We tried it on a couple of claims and we were paid. But now one of the insurance companies is requesting a refund. Should we return the payment? It wasn’t very much money. But if they want the money back, it makes me think we shouldn’t have billed it. But that coding company said we could!

Answer:
Yes, you should return the money. The AANS says that intraoperative ultrasound is included in the global surgical package for the neurosurgery codes and it makes sense. If you’re going to bill for removing a brain tumor then you’re expected to find it after the incision has been made and you’re in the operative field. Do not report 76998 (Ultrasonic guidance, intraoperative).
*This response is based on the best information available as of 03/31/16.