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](#).
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.

STAY UPDATED WITH KZA LERTS

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.

STAY UPDATED WITH KZA LERTS
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.
Medicare X Modifiers: Use or not Use?

December 15, 2016

Question:
What’s new with the X modifiers established by Medicare? Should we be using them now?

Answer:
As of today, July 7, 2016, Medicare has yet to finalize a formal policy for the use of the X modifiers as a replacement to the 59 modifier. The X modifiers are shown below.

- XE: Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter
- XS: Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure
- XP: Separate Practitioner, A Service That Is Distinct Because It Was Performed By A Different Practitioner
- XU: Unusual Non-Overlapping Service, The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service

At this point, Medicare has given practices the option to use the X modifier or the 59 modifier. Some of our clients tell us that they are using the X modifiers without any payment issues. Be assured that eventually the X modifier will become standard Medicare policy since the intent of these modifiers is to force providers to be more specific regarding the rationale for unbundling two bundled CPT codes. Medicare developed these modifiers to reduce misuse and abuse of the 59 modifier.

*This response is based on the best information available as
Pharyngoplasty With Free Flap Reconstruction

December 15, 2016

Question:
I’m doing the repair of the oral cavity defect with a free flap reconstruction after the head and neck surgeon has resected the cancer. Can I code both 42950 and the free flap code such as 15758?

Answer:
The free flap codes include the harvest, inset, microvascular anastomosis, and closure of both donor and recipient site defects. You may separately code the harvest of graft material through a separate incision (e.g., split thickness skin graft) to facilitate the donor defect closure. So the answer is no, it is not accurate to separately code for a pharyngoplasty when you are insetting the free flap.

A CPT Assistant article from April 2016 addresses this situation in great detail.

Question:
Is code 42950, Pharyngoplasty (plastic or reconstructive operation on pharynx), reportable in addition to code 15757, Free skin flap with microvascular anastomosis, when a free flap is used to reconstruct both a neck and tongue defect (after laryngectomy or glossectomy)? The microvascular free
flap is de-epithelialized and the skin paddle is used to complete the pharyngeal closure. The rest of the flap is used to complete the esophageal closure.

Answer:
No, CPT code 42950 should not be reported in addition to code 15757, when a free flap is used to reconstruct both a neck and tongue defect (after laryngectomy or glossectomy). The intraservice work of code 42950 is encompassed in code 15757, which includes harvesting a donor free flap, insetting the free flap at the recipient site using microsurgical technique, and closure of both donor and recipient sites. The pharyngeal reconstruction should be included in code 15757, as it would for wherever the flap was inserted. In addition, the inclusion of the flap closure should be considered as part of the work included in the basic closure of the primary resection site. This basic closure is inclusive of code 15757.

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

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Diagnosis for Open Wounds as a Result of Cancer Resection

December 15, 2016

Question:
What diagnosis code do we use when we are reconstructing a defect after the Moh’s surgeon, or someone else removed the cancer? When I try to crosswalk the ICD-9-CM open wound code I used to something in ICD-10-CM, it takes me to an S code which
is strange because the open wound is not the result of an injury or trauma.

Answer:
Good question! Technically, you would not use a cancer diagnosis code since you are not treating cancer (the Moh’s surgeon treated the cancer by excising it). Your diagnosis codes, as the surgeon treating an open wound/resulting defect resulting from cancer resection are:

1. Z48.1 Encounter for planned postprocedural wound closure, and
2. Z42.8 Encounter for other plastic and reconstructive surgery following medical procedure, and
3. Personal history of neoplasm code (e.g., skin Z85.82-, melanoma Z85.820). If the reconstruction occurs on the same day as the cancer removal, then the C code for malignant neoplasm can be substituted for the Z85.- code.

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