ICD-10-CM for Otitis Media

September 24, 2015

Question:

I am hoping that ICD-10-CM has codes for recurrent acute otitis media since this is one of the most common reasons why we put in tympanostomy tubes. Did this happen?

Answer:

Yes – someone must have heard you! Many of the otitis media codes now specify acute, acute recurrent, and chronic. Laterality is also a prominent issue with the ear codes. For example, serous otitis media has the following specific codes:

H65.01 Acute serous otitis media (ASOM), right ear
H65.02 ASOM, left ear
H65.03 ASOM, bilateral ears
H65.04 Acute recurrent serous otitis media (ARSOM), right ear
H65.05 ARSOM, left ear
H65.06 ARSOM, bilateral ears
H65.21 Chronic serous otitis media (CSOM), right ear
H65.22 CSOM, left ear
H65.32 CSOM, bilateral ears

*This response is based on the best information available as of 09/24/15.

Acellular Dermal Matrix
Placement for Breast Reconstruction

September 24, 2015

Question:
I’m doing bilateral tissue expander breast reconstructions and will be using ADM. Is there a separate code for the ADM?

Answer:
Yes, there is. In addition to 19357 (Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion) you can report an add-on code, +15777 (Implantation of biologic implant (e.g., acellular dermal matrix) for soft tissue reinforcement (e.g., breast, trunk)) (List separately in addition to code for primary procedure). You can report both codes bilaterally, with modifier 50.

*This response is based on the best information available as of 09/24/15.

ICD-10-CM for Bilateral Carpal Tunnel Syndrome

September 10, 2015

Question:
I noticed that the ICD-10 carpal tunnel syndrome diagnosis codes are specific for right and left. What happens if the patient has bilateral carpal tunnel syndrome – how should I
code it?

Answer:

Good question, because many ICD-10-CM codes have right, left and bilateral codes; although the codes for carpal tunnel syndrome do not have a bilateral option. Here’s what we’ve got in ICD-10-CM for carpal tunnel syndrome:

G56.01 Carpal tunnel syndrome, right upper limb
G56.02 Carpal tunnel syndrome, left upper limb

But there is not a code for bilateral carpal tunnel syndrome. So if the patient has bilateral carpal tunnel syndrome, you will use both ICD-10-CM codes: G56.01 and G56.02.

*This response is based on the best information available as of 09/10/15.

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**Dry Needling**

September 10, 2015

**Question:**
We are receiving conflicting information on the correct coding for a “dry needling” procedure. Is it possible that Mary LeGrand can answer this question for us?

**Answer:**
Thank you for reaching out to KZA for your coding needs. We are not surprised that confusion exists related to this procedure. The correct code for this procedure is an unlisted code: Unlisted procedure, musculoskeletal system, general. Remember to check payor policies and Medicare LCDs as this may be a non-covered service.
ICD-10-CM for Bilateral Cerumen Impactions

September 10, 2015

Question:

I noticed that the ICD-10 codes for many ear conditions are specific for right, left and bilateral. But what if I am billing for a bilateral procedure, such as tympanostomy tubes? Should I use the right and left codes, or should I use the bilateral code?

Answer:

Good question! If a bilateral code exists and the disorder is documented as bilateral, then the bilateral code should be used. You would not use the individual right and left codes just because you are billing bilateral procedures even if you are line-item billing the procedure (i.e., 69436 and 69436-50).

*This response is based on the best information available as of 09/10/15.*
ICD-10-CM for Bilateral Conditions

September 10, 2015

Question:

I noticed that the ICD-10 codes for many conditions are specific for right and left. I also noticed that some conditions have a specific code for bilateral. But what if the patient has bilateral disease but there is not a diagnosis code for bilateral? Should I use an unspecified code?

Answer:

Good question! No, don’t use an unspecified code. The laterality is specified in your documentation, so an unspecified code is inaccurate. If a bilateral code exists and the disorder is documented as bilateral, then the bilateral diagnosis code should be used. But if the documentation states the condition is bilateral, and there is not a bilateral diagnosis code, then use both the right and left codes.

Watch for Kim Pollock’s upcoming webinars on ICD-10 coding for plastic surgery and breast procedures...more information shortly!

*This response is based on the best information available as of 09/10/15.

63005 vs. 63047

August 27, 2015
Question:
Help me understand the difference between 63005 and 63047 – I don’t get it! The codes look the same to me.

Answer:
Yes, it can be confusing because the code descriptions are very similar. However, look very carefully and you’ll see the differences. Here are the code descriptions and I’ve bolded some key differences:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>63005</td>
<td>Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy, (e.g., spinal stenosis), one or two vertebral segments; lumbar, except for spondylolisthesis</td>
</tr>
<tr>
<td>63047</td>
<td>Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root(s), (e.g., spinal or lateral recess stenosis)), single vertebral segment; lumbar</td>
</tr>
</tbody>
</table>

CPT 63005 is generally used for removal of the lamina to provide central decompression of the spinal cord. CPT 63047 involves not only removal of lamina for central decompression but also lateral recess decompression in the form of a facetectomy (e.g., medial, partial) and/or foraminotomy for nerve root decompression.

*This response is based on the best information available as of 08/27/15.*
Can Physical Therapy Services Be Reported Incident-To a Physician Assistant?

August 27, 2015

Question:
I am a Physician Assistant and I have a question about code 97110 and reporting services to Medicare. Can I report CPT code 97110 to Medicare under my name and NPI if I evaluate and develop a rehabilitation plan of care for a patient and the medical assistant in our office performs the exercises and documentation?

Answer:
No, Medicare does not recognize a medical assistant as a qualified therapy provider; any services performed by the medical assistant are not reportable to Medicare by yourself, the PA. Additionally, Medicare has specific rules addressing who may provide and when Incident-To services may be reported.

*This response is based on the best information available as of 08/27/15.

Bilateral Diagnoses

August 13, 2015

Question:
I understand there are more diagnosis codes for bilateral procedures in ICD-10-CM. This makes sense and I get it. But I
noticed that there are some diagnosis codes that don’t have a “bilateral” option. What should we do?

**Answer:**

Good question! And we agree that having some diagnosis codes that reflect laterality is a good idea. Some of the ICD-10-CM cerebrovascular diagnosis codes have right, left and bilateral options. However, some don’t have a bilateral option. The same is true for carpal tunnel syndrome – there are right and left diagnosis codes but not a bilateral code. So how should you code if a diagnosis is bilateral and a bilateral code does not exist? You’ll use both the right and left diagnosis codes in those cases. We cover this issue and many more in our two neurosurgery-specific ICD-10-CM webinars that you can find here:

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**Different Specialties, Same Tax ID**

August 13, 2015

**Question:**

Can you help clarify the new patient rules related to multiple specialties in the same group practice? If we have different specialties (e.g., Pain Management, Podiatry, Rheumatology, Orthopaedics) can we charge a New Visit code when the patient is seen for the first time by a physician in a different specialty in the practice?

**Answer:**

Yes, the CPT rules and Medicare rules both allow the new patient visit rules in your scenario, which is very common in
large multi-specialty groups or academic centers where all specialties bill under the same tax ID. The following is a direct citation from the 2015 AMA CPT Manual: “Solely for the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services reported by a specific CPT code(s). A new patient is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.”

Thanks for reaching out to KZA for your coding needs!