Question:

Do you advise that we hold our claims for excision of skin lesion procedures until after the pathology report is received? That seems to delay our charges and I want to get them billed quickly!

Answer:

Yes, you need to hold the claim for the excision of skin lesion codes (114xx for benign skin lesions, 116xx for malignant skin lesions) if you do not have a previous pathology report showing a malignancy. Why? Because the CPT codes for the procedures require the lesion pathology be identified. If you have a biopsy report for the lesion showing a malignancy, then you can go ahead and bill the excision procedure using the malignant CPT (116xx) and diagnosis codes.
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**Merging Practice and Patients**

**Question:**

We recently had a surgeon merge his practice with ours. Can I bill his patients as new (99201-99205) when they are seeing the same physician but he has joined/merged with our practice? We will be billing using our tax ID/NPI number. They have seen him previously under his old tax ID/NPI.

**Answer:**

Even under a new tax ID number, once the practices have merged, any patients seen by the new physician(s) within the past 3 years will be established patients to the new physician and all physicians of the same specialty in the newly merged practice.
ICD-10-CM  7th  Character Extension

July 30, 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 neurosurgery, the most common categories of codes include pathological fractures (M80, M84), traumatic injuries (S00-S39), and complications such as shunt malfunctions (e.g., T85). 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, P, S) is used when the patient has completed active treatment.

Cast Changes During the Global Period

July 30, 2015

Question:

We have not been billing for cast changes during the global period, but have recently been told we should be reporting this service. In our orthopedic physician practice, on
occasion a patient will require a cast change (for various reasons). If the physician orders the cast change and is present in the office during the cast change by our cast technician, can we bill Medicare during the 90-day global period?

**Answer:**  
Thanks for your specific question and recognition that Incident-To rules apply in your scenario. Yes, if the physician orders the cast re-application and is in the office while the technician applies the cast, the service is billable to Medicare. Append modifier 58 to the cast application code since the patient is in a global period. Supplies are also reportable assuming the practice incurs the expense.

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**Lipoma Removal**

**July 30, 2015**

**Question:**

I removed a huge lipoma from a patient and it seems like the benign skin lesion removal codes just don’t describe what I’m doing. Is there another code I can use?

**Answer:**

Yes! The “soft tissue tumor” codes were introduced into CPT in 2010 and better describe the procedure you are performing. These codes are located in the Musculoskeletal System section of CPT (e.g., 21555, 21556) rather than in the Integumentary System section of CPT (114xx for excision of benign skin lesions, 116xx for excision of malignant skin lesions).
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**Tumor Embolization**

July 16, 2015

**Question:**

I embolized a neck tumor through two separate arteries (the right inferior thyroid artery as well as the left inferior thyroid artery). Do I code 61626 once or twice? Also, I performed follow-up angiography twice so can I bill 75898-26 x 2 or just once?

**Answer:**
Good questions! CPT 61626 is reported once in your situation because there was only one tumor, or surgical site. As for the follow-up angiography, CPT guidelines allow reporting 75898 per follow-up angiography performed and documented so you may bill it twice. That said, some payers, including Medicare, allow payment of only one unit.

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**Embolizing the Internal Iliac During an EVAR**

**Question:**

During an EVAR I embolized the internal iliac. Can I code separately for that?

**Answer:**

Yes. The internal iliac is outside the target zone of the endograft, so an intervention in that vessel may be reported separately. You would bill 37242-59 for the embolization. If the catheterization of the internal iliac is also documented, report 36246 for the second order catheterization. Remember, if you catheterized the aorta with bilateral catheters (36200-50) one of those non-selective catheter placements will now be bundled into the selective catheterization, 36246.
New or Established Patient Visit?

July 16, 2015

Question:
If a patient presents as a new patient visit and the surgeon reports an injection only, can the surgeon report a new patient visit when the patient returns for the follow up visit?

Answer:
No, the surgeon had a face-to-face encounter with the patient to perform the injection; thus, the follow up visit within the three year period is an established patient visit.