Dialysis Access Creation in Lower Extremity

December 1, 2016

**Question:**
I created an AV access in the leg. What code do I use for this?

**Answer:**
The CPT codes for AV graft or fistula creation apply to the lower extremity as well as the upper extremity. Take a look at codes 36281-36830 for the most appropriate code for the procedure you performed.

**WEBINAR ALERT!**
The codes for AV access/dialysis circuit imaging and interventions all change on January 1, 2017. Join Teri Romano for a webinar on these and other new vascular codes on December 14, 2016. [Click here for more information and registration.](#)

*This response is based on the best information available as of 12/01/16.*
Moderate Sedation Coding in 2017

December 1, 2016

Question:
I see there are new moderate sedation codes in the 2017 CPT manual. Why were these changed?

Answer:
Moderate sedation codes, 99143-99145 codes have been deleted and replaced by codes, 99151-99157. These are part of a Medicare-initiated revision regarding the use of moderate sedation. All codes that previously included moderate sedation as an inherent part of the codes, such as EGD and colonoscopy, have now been revalued to exclude the sedation. As a result, if you personally supervise moderate sedation, you will now report the sedation separately. Tune in for a webinar on December 15th to hear what prompted that change.

WEBINAR ALERT:
For more detailed information about Medicare and private payer billing under these new guidelines, please join Teri Romano for a thirty minute Zipinar on December 15, 2016, focusing on the coding and reimbursement changes for endoscopy procedures. Click here for more information and registration.

*This response is based on the best information available as of 12/01/16.
Global Period for ICP Monitor

December 1, 2016

Question:
I did a consultation on an ICU patient (non-Medicare) and placed an intracranial pressure monitor (ICP) via twist drill on a patient this morning. The global period for the ICP monitor code, 61107, is 90 days so I now can’t bill for any follow-up hospital care. What’s the point – I should just not bill for the ICP monitor placement so I can continue to bill for follow up hospital care.

Answer:
Actually, the postoperative global period for 61107 is not 90 days. Rather, it is 0 days so you may continue to bill your follow up hospital care using a subsequent hospital care code (9923x).

For today’s services you’ll report the consultation code, 9925x, appended with modifier 25 as well as 61107.

*This response is based on the best information available as of 12/01/16.

Bilateral Nasal Vestibular
Stenosis/Valve Repair

December 1, 2016

Question:
I’ve been billing 30465 and 30465-50 for bilateral. I’m having a hard time getting paid on the second side (30465-50). Should I use modifier 59 instead of modifier 50?

Answer:
No! CPT guidelines state to use modifier 52 (reduced services) on 30465 if only one side is corrected. Therefore, 30465 implies both sides were surgically corrected and it would be inappropriate to append modifier 50 (bilateral procedure).

*This response is based on the best information available as of 12/01/16.

Trigger Point Injections, More Than One Muscle

November 17, 2016

Question:
My physician performed two trigger point injections in two different muscles. Would it be appropriate to report code 20552 twice for the two injections?

Answer:
No, code 20552, trigger point injection(s) single or multiple trigger point(s) is for injection of 1 or 2 muscles. If more
than 2 muscles are injected only 20553, trigger point
injection(s), three or more muscles, is reported.

*This response is based on the best information available as
of 11/17/16.

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Surgical Modifiers: How Do They Impact Reimbursement?

November 17, 2016

**Question:**
What reimbursement should we expect when using the global period modifiers 58, 79 and 78?

**Answer:**
Surgical modifiers are used to indicate that a subsequent procedure was performed during the global period of a prior surgery. Modifiers tell the payer the rationale for allowing payment for this subsequent procedure. The modifiers and reimbursement impact of each is shown below:

**Modifier 58:** to indicate a second procedure was performed as a staged procedure. Reimbursement should be 100% of the allowable fee.

**Modifier 79:** To indicate an unrelated procedure was performed during the global period of the original procedure. Reimbursement should be 100% of the allowable fee.

**Modifiers 78:** To indicate that a complication of an original procedure was treated by a return to the operating room,
catheterization or endoscopy suite. Reimbursement should be at 70-80% of the allowable fee. This reduction reimburses for the intra-operative portion of the procedure only, since the patients pre and post-operative services are paid under the original surgery’s flat fee.

*This response is based on the best information available as of 11/17/16.

Bilateral Nasal Vestibular Stenosis/Valve Repair

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Reporting for Placement of a Non-biodegradable Antibiotic-impregnated Cement Spacer After Total Joint Prosthesis Removal

November 17, 2016

Question:
In a recent case review you performed for us, you reported CPT code 11981-51 (Insertion, non-biodegradable drug delivery implant) when our physician removed an infected hip prosthesis and placed a non-biodegradable antibiotic-impregnated cement spacer as part of a multi-stage revision. We had not used this code in the past because the prosthesis removal code, 27091, includes the text “with or without insertion of spacer.” Can you explain this further?

Answer:
You are correct that the definition of 27091 refers to placement of a spacer. We are able to report 11981 in addition to the prosthesis removal code because the spacer is incorporating the non-biodegradable antibiotic drug that is used to treat the patient’s infection. Refer to CPT codes 11981, 11982, and 11983 for the CPT insertion, removal, and exchange codes for non-biodegradable drug delivery implant. Remind the physicians to reference the non-biodegradable antibiotic-impregnated cement in the operative note, as placement of biodegradable drug-delivery devices is not separately reportable.
2017 Reimbursement Reductions for Endoscopy: How Much Will It Impact My Revenues?

November 17, 2016

Question:
My partner mentioned that she heard all our endoscopy codes are being reduced in payment starting January 1, 2017. I don’t know if we can take one more major reduction in reimbursement. Can you clarify this??

Answer:
Reimbursement changes to endoscopy codes will be effective on January 1, 2017. However, if you understand how to code these procedures under the revised 2017 coding rules, the impact on your revenues could be zero. That’s the good news. However, it will be essential to code these correctly and to establish processes in your practice to ensure you capture all revenues under the new guidelines. Very simply, the value of moderate sedation has been carved out of all endoscopy codes. However, if you perform moderate sedation, you will be able to bill for this activity under a new Medicare G code (for Medicare patients) combined with new CPT Category I codes for moderate sedation.
WEBINAR ALERT:
For more detailed information about Medicare and private payer billing under these new guidelines, please join Teri Romano for a thirty minute Zipinar on December 15, 2017, focusing on the coding and reimbursement changes for endoscopy procedures. Click here for more information and registration.

*This response is based on the best information available as of 11/17/16.

Additional Information About Assistant Surgeon on 61323

November 17, 2016

Question:
Thank you so much for your help in getting 61323 payable for an assistant, we appreciate it! When will this become effective and can we bill retrospectively for services in the past year?

Answer:
You are welcome! This change becomes effective 1/1/2017 and unfortunately, retroactive payment is not likely. You can try, but we doubt it will happen.

*This response is based on the best information available as
of 11/17/16.