Diagnosis for Open Wounds as a Result of Cancer Resection

November 17, 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 11/17/16.
Extremity Angiogram (75710) With AV Graft Imaging (36147). Is It Separately Billable??

November 17, 2016

Question:
In evaluating an occluded AV graft, I punctured the graft and performed a dialysis circuit venogram, for which I billed 36147. If I had a concern about occlusive disease in the arterial inflow, and performed and documented an arteriogram of the same arm, can I bill a 75710?

Answer:
Great question! Code 36147 includes imaging of the venous outflow (up to and including imaging of the inferior and superior vena cava) and the peri-anastomotic portion of the arterial anastomosis. The peri-anastomotic section includes the short segment of the artery immediately adjacent to anastomosis and the anastomosis itself. If there is documented medical necessity to evaluate the arterial patency in the same extremity not generally considered to be part of the AV graft, that angiogram may be reported with 75710. This will also typically require more selective catheterization into the involved artery. This may be reported with a 36215 for a first order catheterization.

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 11/17/16.

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**Acromioclavicular Joint Billing**

October 27, 2016

**Question:**
When our physician performs an injection into the acromioclavicular (AC) joint of a patient in the office, can we bill 20610 for a large joint arthrocentesis? I say yes because it is in the shoulder, which is listed as an example large joint in the code descriptor.

**Answer:**
No. The correct code to bill in this case would be 20605 for an intermediate joint. Although the AC joint is between the shoulder and the clavicle, it is considered an intermediate joint. If you look at the example intermediate joints in the descriptor for 20605 they include: temporomandibular, acromioclavicular, wrist, elbow or ankle, or olecranon bursa. The example large joints listed for code 20610 include:
shoulder, hip, knee, subacromial bursa. If the physician performs the AC injection utilizing ultrasound guidance with permanent recording and reporting, then you should report code 20606 instead of 20605. And don’t forget to bill the HCPCS II code for the medication itself.

*This response is based on the best information available as of 10/27/16.

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Removal of Mandibular Interdental Fixation

October 27, 2016

**Question:**
We did a mandibular fracture repair on a patient (car accident) and placed the interdental fixation as part of the fracture repair. We saw the patient in the office, about 8 weeks postop, for a visit and everything was looking good so we removed the wires/fixation. Is the removal separately billable or included in the global fee?

**Answer:**
Good question! The removal of the interdental mandibular fixation (IMF) is included in the global period when performed in the office setting. If you think about it, you put the IMF on so it is up to you to take it off.

*This response is based on the best information available as of 10/27/16.
Surgical Modifiers: How Do They Impact Reimbursement?

October 27, 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.
CPT Coding for Converting to an Open approach

October 27, 2016

Question:
My doctor started a laparoscopic cholecystectomy that had to be converted to open due to significant adhesions. He documented both approaches and the laparoscopic approach took significant time before he had to convert to open. Can both be billed?

Answer:
Unfortunately, no. Whenever a “closed” procedure (laparoscopic, arthroscopic, endovascular) is converted to an open procedure only the open procedure may be reported. If a significant amount of time was spent attempting the closed procedure, and this is documented, a 22 modifier for increased procedural services may be appended to the open code. Don’t forget to add the appropriate diagnostic code to indicate the conversion. See the appropriate diagnosis codes below.

- Z53.31 Laparoscopic procedure converted to open
- Z53.32 Thoracoscopic procedure converted to open
- Z53.33 Arthroscopic procedure converted to open
- Z53.39 Other specific procedure converted to open
Assistant Surgeon on CPT 61323

October 27, 2016

Question:
We got a denial for assistant surgery charges by our PA for CPT 61323 with the reason as Medicare disallows. I looked at Medicare’s guidelines and confirmed this. It seems rather odd that they would not pay for assist on brain surgery but routinely do on laminectomies and discectomies. What are your thoughts?

Answer:
I also looked at Medicare’s guidelines and saw that Medicare does allow an assistant to be paid on CPT 61322 but not on 61323. This didn’t seem right to me – perhaps an oversight when the codes were introduced in 2003.

So I asked the neurosurgery specialty societies to help rectify the issue. Success! They were able to get Medicare to approve 61323 for assistant surgery payment (modifier 80, 82, AS). Thank you for being an “eagle-eyed administrator”!

*This response is based on the best information available as of 10/27/16.
Endoscopic Septoplasty

October 27, 2016

Question:
Is there a code for an endoscopic septoplasty?

Answer:
There is not a separate code for an endoscopic septoplasty nor is there an add-on code for the endoscope. You’ll use 30520, the usual septoplasty code.

*This response is based on the best information available as of 10/27/16.

Reimbursement: Assistant Surgeon

October 27, 2016

Question:
What is the reimbursement for an assistant surgeon using modifier 80? Is the payment different for the primary and the assistant?

Answer:
Assistant surgeon is described as one surgeon, of the same or a different specialty, providing assistance during a surgical procedure or CPT code. Modifier 80 (modifier 82 for an
assistant surgeon in an academic setting when a qualified resident is not available) is appended to any CPT code the assistant participates in. Medicare reimburses 16% of the allowable for the assistant surgeon (modifier 80 or 82), to the codes where an assistant payment is allowed, and multiple procedure/bilateral procedure reductions also apply. The primary surgeon’s fee is not affected. In an assistant surgeon scenario, the assistant need not and should not dictate a separate note. However, it is critical that the primary surgeon document in his/her note, specifically what the assistant did. Stating an assistant was needed because the case was complex is not sufficient. The primary surgeon must state what the assistant did, for example, assisting with the resection, anastomosis, etc. For private payers, coding guidelines and payment may vary.

*This response is based on the best information available as of 10/27/16.

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**Piriformis Syndrome Injection**

October 27, 2016

**Question:**
How do you code an injection for piriformis muscle for piriformis syndrome?

**Answer:**
An injection for piriformis syndrome is trigger point injection and is reported with code 20552, trigger point injection(s) single or multiple trigger point(s), 1 or 2 muscles.
*This response is based on the best information available as of 10/27/16.*