Question:

I do a lot of reconstruction procedures after the Mohs surgeon has removed the skin cancer. I am not removing cancer so it doesn’t seem right to use a cancer diagnosis code. But what diagnosis code should I use?

Answer:

We recommend using an “open wound” diagnosis code since the purpose of your procedure is to close an open wound. You can use the cancer diagnosis code as a secondary diagnosis code.
Getting Ready for ICD-10-CM

July 2, 2015

Dear friends,

In an effort to help you get ready for ICD-10-CM implementation on October 1, 2015, we will answer some diagnosis coding questions in future editions of the Coding Coach. Watch our ICD-10-CM webinars, such as Teri Romano’s upcoming “ICD-10 Training for Non-Traumatic Spine Disorders: Disc, Stenosis, and More!!” on July 7th.

Question:

How do you code lumbar spinal stenosis with radiculopathy?

Answer:

Good question because some spine conditions have a combination code that addresses both problems such as M50.12 for a C4-C5 herniated disc with radiculopathy. However, there is no such combination code for spinal stenosis with radiculopathy. Therefore, you’d use the individual lumbar stenosis code (M48.06) and the lumbar radiculopathy code (M54.16).

Revisions of Upper Arm Bypass

Question:

How do I report a revision of an upper arm bypass?
Answer:

Unfortunately, there is no CPT code for an upper arm bypass revision. An unlisted code is used for this procedure. To set your fee, use the lower extremity revision code for comparison purposes.

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**CPT or HCPCS Tool?**

July 2, 2015

**Question:**
We have recruited a new hand surgeon and she frequently applies aluminum finger splints which are molded by the surgeon or her medical assistant. Can we report CPT code 29130 for the application and molding of this splint?

**Answer:**
Thanks for this great question! The application of the splint code 29130 is not reportable for an off the shelf product such as the aluminum splint. Report the appropriate HCPCS code for the supply only.

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**Nasal  Sinal  Displacement  Therapy**

July 2, 2015

**Question:**
After bilateral endoscopic sinus surgery is completed, my doctor documents “the patient then underwent bilateral nasal sinal displacement therapy and all bloody secretions and mucoid secretions were clear.” He wants to bill 30210-50 (Displacement therapy (Proetz type)) in addition to the endoscopic sinus surgery codes. Is that acceptable?

Answer:

No. Irrigation of the operative field is included in the global surgical package of the primary procedure code(s) and not separately reported.

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**Panniculectomy**

July 2, 2015

Question:

How can I get insurance to pay for a panniculectomy? The patient lost 150 pounds and has excessive abdominal skin and subcutaneous tissue.

Answer:

Good question! Most payers have a medical policy (also known as “medical necessity”) that must be followed to obtain prior approval for the procedure. Ask the payer, or look on their website, for the policy to make sure you follow their guidelines.
Question:
I’m trying to figure out how to code a procedure for precertification. My neurosurgeon said she’s going to do a T10-S1 fusion. She’s doing a combined interbody and posterolateral fusion (22633) at L4-L5 and posterolateral fusions at all the other levels. Do I code 22610 for the thoracic fusion with modifier 59 along with 22633 (L4-L5, combined fusions) and 22614 x 6 units for the other levels?

Answer:
Not exactly, but good try! You’ll report only one stand-alone code (22633 for the L4-L5 combined fusions) and 22614 x 7 units for the additional levels of posterolateral fusion. It is not accurate to also report 22610. Don’t forget to report the other codes such as for the instrumentation and bone graft.

Medicare Coverage Policies for Vascular Surgeons

Question:
My coder mentioned following an “LCD”. What is an LCD and how does it apply to vascular surgery?

Answer:
LCD is an acronym for Local Coverage Decision (or
An LCD outlines Medicare’s coverage policy for a specific procedure or service. Most Medicare carriers have an LCD for varicose vein surgery, non-invasive imaging, wound therapy and other procedures specific to vascular surgery. An LCD describes the criteria that must be met for the procedure to be covered (paid for) by Medicare. Documentation requirements and required diagnosis codes are typically part of an LCD. Criteria in these LCDs must be closely followed in order for a procedure to be considered medically necessary. Non-compliance with an LCD is a major audit target for Medicare and can result in significant re-payment demands.

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**Medicare Incident-To Billing Rules**

June 11, 2015

**Question:**
We have a new PA in our office and we want to make sure we are billing correctly when we bill for his services Incident-To the physician. Am I correct to assume that when a new Medicare patient is seen in our office that the physician has to see the patient, examine the patient, and develop the plan of care him or her, and, on the next visit, the PA can implement the plan of care and bill Incident-To assuming the physician or another supervising physician is in the office?

**Answer:**
Yes, to report services Incident-To (meaning implementing the plan of care and physician in the office), the physician must independently obtain the History of Present Illness, must independently perform the exam, and all the decision making components including ordering and reviewing of tests, making
the diagnosis and determining the plan of care. Assuming the physician performs this work, the PA may implement (not change) the plan of care and report services Incident-To the physician if the physician or another supervising physician is in the office.

Incident-To services do not apply to the first visit for a new patient, established patient with a new problem, a visit where the PA changes the plan of care or when a physician is not in the office. Incident-To services also do not apply in the hospital setting.