Harvest of Abdominal Fat Graft

June 11, 2015

Question:

My doctor harvested abdominal fat that he then used in the nose to close the area when he did an endoscopic removal of a pituitary tumor (62165). I want to bill 15770 but my doctor thinks the correct code is 20926. What do you recommend?

Answer:

Your doctor is correct with 20926 (Tissue grafts, other (e.g., paratenon, fat, dermis)). CPT 15770 (Graft; derma-fat-fascia) is used for a composite graft when more than one layer of tissue is harvested and placed (e.g., fat and fascia). When only one layer of tissue is harvested, such as fat, then report 20926.

Excision of Excess Breast Tissue After Breast Reconstruction

June 11, 2015

Question:

During the second stage of tissue expander breast reconstruction, when I’m removing the tissue expander and placing the permanent prosthesis, I also excise some lateral
excess tissue to give a better cosmetic result. Can I charge 19380 (Revision of reconstructed breast) for this in addition to the code for the exchange procedure?

Answer:

No, this is not an accurate use of 19380. Typically this service is included in the code for the primary procedure.

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63075 with 22551

May 21, 2015

Question:

We are used to billing 63075 with 22551 and putting modifier 59 on 63075 to indicate these procedures were separate. We’re getting more and more denials on 63075. What can we do to get these paid?

Answer:

Actually, 63075 (anterior cervical discectomy and decompression) is included in 22551 (anterior cervical discectomy, decompression and fusion) so these two codes should not be billed together for procedures at the same spinal level. Do not append modifier 59 to 63075; in fact, do not bill these two codes together for procedures at the same level.
Medicare Elimination of Global Periods

Question:
I’ve heard that Medicare will be eliminating the global period and soon I can bill for post-op visits. Is this true?

Answer:
In the calendar year 2015, Medicare Physician Fee Schedule final rule, the Centers for Medicare and Medicaid Services (CMS) proposed an elimination of the zero day global period in 2017 and the 90 day global period in 2018. Under this proposal, post-operative visits would be separately reported. However, Medicare has decided not to go forward with this proposal and will instead evaluate the appropriateness of the current value of post-operative visits as part of the global package. This means that the current global surgery rules, which bundle post-operative visits, still apply. Watch the Medicare website and look for KZA Alerts for updates on this issue.

Injection Code 96372, Is This Correct?

May 21, 2015

Question:
I am new to orthopaedic coding, having just left a Family Practice group after many years. The surgeon said he did an injection to the flexor tendon sheath of the right index
finger. I want to verify that CPT code 96372 is correct for the injection. I am very familiar with reporting the J codes for the drugs.

**Answer:**
Welcome to the world of Orthopaedic Coding! Your question is one that we receive on occasion when someone like yourself has taken the huge leap from the world of a medical practice into surgical coding. You will now want to familiarize yourself with the musculoskeletal section of the CPT book.

In the musculoskeletal section, find the section titled Introduction or Removal (20500-20697). You will see a list of codes beginning with CPT code 20500 through 20612 which will cover the majority of injections performed in a general orthopaedic practice. You state the injection was given to the flexor tendon sheath, thus the correct code will be 20550, Injection(s); single tendon sheath, or ligament, aponeurosis (e.g., plantar “fascia”). Kudos to the surgeon for the great documentation of exactly where the injection was administered. The appropriate J code may be reported in addition to CPT code 20550, as you are familiar with doing.

You may find it beneficial to set up a contract with KZA and work with Mary LeGrand on any of your coding or practice management needs. This relationship can be developed remotely and allow you access to Mary for any coding questions, assistance with operative notes, appeals, or audits. You may also consider attending an AAOS sponsored coding course.

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**Paramedian Forehead Flap**
After Mohs Surgery

May 21, 2015

Question:

I did a paramedian forehead flap after the Mohs surgeon removed the cancerous lesion from the nose. What is the CPT code for this procedure and do I need a modifier because I’m in the Mohs surgeon’s global period?

Answer:

The code is 15731 (Forehead flap with preservation of vascular pedicle (e.g., axial pattern flap, paramedian forehead flap)). You should not need a modifier because you are a different specialty (Otolaryngology) from the Mohs surgeon (Dermatology) and payers should not consider you to be in the Mohs surgeon’s global period.

Repair of Nasal Vestibular Stenosis

May 21, 2015

Question:

I will sometimes do a septoplasty with the repair of nasal vestibular stenosis. Is it OK to bill both codes together?

Answer:

Yes, it sure is, assuming the documentation supports both separate services. CPT 30520 (septoplasty) is not included in
the code for nasal vestibular stenosis repair (30465, Repair of nasal vestibular stenosis (e.g., spreader grafting, lateral nasal wall reconstruction)) and may be separately reported. However, if you’re only harvesting cartilage from the septum, then you’d report only 20912 (Cartilage graft; nasal septum) and not 30520.

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**AV Graft Coding**

**Question:**

In order to treat occlusion of an AV graft, I had to angioplasty both the venous portion and the arterial anastomosis. Can I report both 35475 for the arterial angioplasty and 35476 for the venous angioplasty?

**Answer:**

CPT rules specify that only one angioplasty may be reported for the AV circuit portion of the graft, which includes the entire graft up to and including the auxiliary vein and the peri-anastomotic portion. So in your scenario, only one angioplasty would be reported.

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**E&M Selection Based on Time**

May 7, 2015

**Question:**

Our surgeon saw a patient in the office following a shoulder MRI. In the visit, the surgeon documented, “I had a very long
face-to-face discussion with the patient today regarding their shoulder MRI. I spent over 20 minutes in the exam room discussing the results of the scan, reviewing the MRI with the patient, discussing the findings, pathology of the disease process and discussing operative versus non-operative management. The patient has chosen to start first with physical therapy but understands that due to the pathology at this time, surgery may be required in the future.” The surgeon has stated that this visit should be based on time because there was no medical necessity to repeat all the history and exam information as nothing had changed since the prior visit. In looking at the note, I do not believe the documentation requirements are met to select a code based on time. Can you please advise?

Answer:
Thanks for reaching out. Your question is a great question and the scenario an excellent one to educate the surgeon on closing the documentation gaps required when counseling and coordination are the exceptions to selecting a code based on the three key components. To report a service based on time, three key elements must be documented: 1) the total face-to-face time between the surgeon and, in this case, and the patient. It is not the time the patient is in the office, but the total face-to-face time only. 2) that greater than 50% of the time (or the specific amount of time equaling a unit greater than 50%) was spent counseling or coordinating care and 3) the nature of the discussion or work must be documented. In your scenario, two of the three elements are present, but what is missing is the statement related to the amount of the face-to-face time that was spent with the patient. Without all three elements, the code selection reverts to the three key components.
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May 7, 2015

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Answer:

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