Bilateral Spinal Instrumentation

November 13, 2014

Question:

Can I bill the posterior instrumentation codes such as 22840 and 22842 with modifier 50 because I do put pedicle screws and rods on both sides of the spine?

Answer:

Good try, but no. The spine is considered a central structure for purposes of the instrumentation codes, so it is not appropriate to append modifier 50 to the posterior instrumentation codes. It also is not accurate to append modifier 50 to the anterior instrumentation codes (e.g., 22845) or the intervertebral device code (22851).

Popliteal Thrombectomy with Fem-pop Bypass. Is it Billable?

Question:

During a fem-pop bypass a clot was dislodged and I had to do a popliteal thrombectomy. Is that separately billable?

Answer:

Any procedures performed to establish inflow and outflow
during an open vascular procedure are included in the primary procedure. Therefore, a popliteal thrombectomy in the same extremity as a fem-pop bypass is included in the bypass code.

**Videostroboscopy/Flexible Fiberoptic Laryngoscopy**

October 30, 2014

**Question:**

I recently purchased a videostroboscopy for my practice and was talking to the rep about how to bill for the service. The rep told me to bill 31575 for the flexible fiberoptic laryngoscopy and also 31579 for the videostroboscopy. I’ve billed both codes a couple of times but we can’t seem to get paid on both codes. Please help!

**Answer:**

Congratulations on the new service and expanding your practice! Unfortunately, you’ve been given inaccurate advice. It is not appropriate to report both 31575 and 31579 for the same service. CPT 31579 includes the flexible fiberoptic laryngoscopy (31575), so we suggest you write off the denials and do not report 31575 with 31579.
Question:

I did a bilateral tissue expander reconstruction with placement of acellular dermal matrix in the soft tissue for reinforcement. I coded this as 19357-50 and 15777-50 but my biller told me I could not bill 15777 with modifier 50. She said 15777 should only be billed once. Is this true?

Answer:

No, it isn’t true. The CPT guidelines directly underneath 15777 in the manual say: For bilateral breast procedure, report 15777 with modifier 50. Therefore, 15777 may indeed be reported with modifier 50.

Medicare and many payors did not set up their systems to acknowledge 15777 as accepting modifier 50 when the code was introduced in 2012. But after the first 3-6 months most of the payors, including Medicare, were on board and recognize modifier 50 when appended to 15777.

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**Bilateral Pedicle Screws/Rods**
Placement

October 30, 2014

Question:

Should I be putting modifier 50 on the posterior instrumentation codes like 22840 and 22842 when I place pedicle screws and rods bilaterally?

Answer:

No. The posterior instrumentation codes (22840-22844) are valued for bilateral placement, so appending modifier 50 is not necessary and also would not be accurate.

SMA Stent – What else can I bill?

Question:

I placed a stent in the superior mesenteric artery. Someone told me this stent code is now bundled. What does that mean?

Answer:

The CPT code for an arterial stent placed in the superior mesenteric artery is reported as 37236. This code was newly defined in 2014, replacing the prior stent code 37205. While the prior code allowed reporting of a guidance radiology supervision and interpretation (S & I) code, the new code includes the S & I code. In addition, 37236 includes all angioplasty in the same vessel as the stent. 37236 still allows separate reporting of a diagnostic angiogram and
nonselective or selective catheterization.

**ICD-10 “X” Placeholder**

October 16, 2014

**Question:**

I recently listened to a webinar on ICD-10. They discussed the X placeholder, but I still don’t understand exactly when to use it. Can you help explain?

**Answer:**

Absolutely we can help! The “X” placeholder has two functions in ICD-10-CM. First, it is used with some codes as a placeholder for future code expansion. It holds the data field to be able to place a new alphanumeric character if the definition of the code is expanded in updates to the code set. ICD-10-CM code H66.3X1 (Other chronic suppurative otitis media, right ear) is an example of how the “X” character is used as a placeholder for future code expansion. The “X” has to remain in the code or it becomes invalid.

The second use of the “X” placeholder is to fill data fields to be able to append 7th characters when the code is less than 6 characters in length. 7th character extensions are added to certain codes to further define the condition.

There are three main 7th character extensions: A-initial encounter, D-subsequent encounter, S-sequela. Fractures are the exception and have different 7th characters. The 7th character extensions are noted at the beginning of each code
category. The codes otolaryngologists will use that require 7th characters are for injuries (e.g., foreign bodies, fractures, open wounds).

Because not all codes are 6 characters in length, an “X” is put in the empty data fields so the 7th character extension can be placed in the 7th character data field. For example, S02.2 is the code for fracture of nasal bones, but per the instructions at the beginning of the code category, this code will require a 7th character extension to be added to the code to make the code valid. Because this code is only 4 characters in length, “X”s are placed in the 5th and 6th data fields to add the 7th character. Therefore, the valid code for a diagnosis of open fracture of nasal bones, initial encounter is S02.2XXB.

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**Anterior Hardware Removal**

**October 16, 2014**

**Question:**

I keep getting a denial when we bill 22855 for the removal of anterior hardware at C5-C6 when I bill it with 22845. The old hardware at C5-C6 was removed so that I could put new hardware on at C4-C5 as part of an ACDF. Someone told me to put modifier 59 on 22855 so that it would be paid. Should I?

**Answer:**

No. CPT guidelines state: “Only the appropriate insertion code (22840-22848) should be reported when previously placed spinal instrumentation is being removed or revised during the same session where new instrumentation is inserted at levels including all or part of the previously instrumented
segments.” You’ve got C5 as an overlapping level between the old and new instrumentation; therefore, it would not be appropriate to bill 22855 for the removal. You would bill only for the placement of new instrumentation (22845). Forcing payment on 22855 by appending modifier 59 is not appropriate.

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**Stenosis of an AV Graft**

**Question:**
When treating stenosis of an AV graft with a stent, do I code an arterial or venous stent?

**Answer:**
Per CPT, the AV graft is considered to be venous and most interventions are coded with the venous intervention codes – in this case, 37238 for stent. The exception is if the stenosis is at the arterial anastomosis and involves the artery just proximal to the graft. An intervention that treats this “peri-anastomotic” segment is coded as an arterial intervention.

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**7th Character Extension in ICD-10**

October 2, 2014
**Question:**

Our practice sees a fair number of patients with a diagnosis of “open wounds”. I was looking at these codes in ICD-10 and noticed a character needs to be added to say whether the encounter is initial or subsequent. Is the first visit with the doctor always A for initial and the follow up visits always D for subsequent?

**Answer:**

When first reading the descriptions associated with the 7th character extensions A and D, it would appear that initial encounter is the first visit and all others visits are subsequent, but this is NOT the case. Initial and subsequent encounters are determined on whether the condition is being actively treated (A) or if the condition is in the healing or recovery phase (D). For otolaryngology, the codes that require 7th character extensions are injuries (e.g., fractures, superficial and open wounds and foreign bodies).

Examples of initial encounter —

A: surgical care, emergency department, evaluation and treatment by a new physician

Examples of subsequent encounters —

D: cast change, medication adjustment, removal of internal or external fixation devices

It will be possible for multiple claims to be submitted with diagnosis codes that have initial encounter for the same condition. If a patient presents to the clinic with a foreign body of the nose, the diagnosis code for the visit would be T17.1XXA (Foreign body in nostril, initial encounter). The foreign body was not able to be removed in the office and required surgical treatment. When the patient has surgery, the diagnosis code would be T17.1XXA (Foreign body in nostril,
initial encounter) because the foreign body is still being actively treated. If the patient follows up after the foreign body has been removed, the diagnosis code would be T17.1XXD (Foreign body in nostril, subsequent encounter) because the active phase of treatment is over and the patient is in the healing phase.