Removing a Portion of a Tissue Expander

October 2, 2014

Question:

I have attended 3 of your meetings in the past – 2 in Dallas and 1 in Boston – you do a great job! I need a little help on coding something. What is the code for removal of a fill port only? We are not removing the tissue expander at all. We are taking the patient back to the operating room to do this and we are not in a global period. The codes that I keep coming back to are 19499 and 20680. Any recommendations?

Answer:

I would not use 20680 or 20670 since these codes are in the musculoskeletal system and generally meant to be used for removal of orthopaedic/bone implants. I recommend using 11971 (Removal of tissue expander(s) without insertion of prosthesis) with modifier 52 (reduced services) since you are not removing the entire expander.

Exposure for Spine Surgery – How Many Levels Can the Co-Surgeon Report?

October 2, 2014

Question:
I asked my colleague, a vascular surgeon, to provide anterior exposure for an anterior lumbar interbody fusion. At times, this exposure allows for a spine procedure at more than one level. Do we add modifier 62 to all ALIF codes (the first level, 22558, and each additional level, 22585) or just the first level (22558)?

Answer:

 Modifier 62 may be appropriately appended to add-on codes (22585) as well as the parent code (22558). If the approach surgeon’s exposure is more extensive to accommodate more than the first level anterior lumbar interbody fusion (22558), then s/he may also report the additional levels with modifier 62. Example: a 2 level procedure would be reported as 22558-62 and 22585-62 for the additional level. Remember, the instrumentation codes (e.g., 22845, 22851) and the bone graft codes (e.g., 20930-20938) may not be appended with modifier 62 according to CPT rules. If the approach surgeon stays for the remainder of the procedure to assist, then the approach surgeon can bill the additional codes with an assistant surgeon modifier such as 80 or 82.

Transcatheter Carotid Stent

Question:

I know Medicare has criteria for when a transcatheter carotid stent is medically covered (paid). We are having a debate regarding whether the criteria related to the percent of arterial occlusion is 70% or 80%. Can you help?

Answer:

In regards to extent of vessel occlusion, Medicare’s current
criteria require a 70% occlusion, evidenced by a catheter-based angiogram at the time of the stenting. For the complete Medicare coverage criteria, click here.

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**Drainage of a Postoperative Seroma**

**September 18, 2014**

**Question:**

We had a patient come into the office for their postop check after an ALIF. The doctor ended up having to drain a small seroma. I sent the claim into Medicare with a 78 modifier, but it was denied as included. Did I use the wrong modifier?

**Answer:**

Payment for complications in the global period will depend on the payer and where the procedure or service is performed. Medicare does not allow separate payment for treatment of complications during the global period unless there is a return to the operating/procedure room (procedure room being in the hospital such as an angiography suite or endoscopy suite). Because the seroma is a complication of the original procedure and it was drained in the office setting, it is included and isn’t separately payable by Medicare.
Question:

One of our doctors did a tympanoplasty on the right ear and a paper patch on the left ear. These codes are bundled. Can I be paid for both procedures? If so, how do I code this?

Answer:

While these codes are bundled, you are right that you should be paid for both procedures in this circumstance. Because the procedures were performed on different ears, modifier 59 should be appended to the paper patch code (the lower valued code) to indicate the separate site surgery. This would specify that the procedures were not performed on the same ear and payors will generally allow for separate payment for both. Some payers may require RT-right ear and LT-left modifiers to indicate performance of the procedure on the specific ear.

Remember that multiple surgery rules will apply. You will be paid 100% of the allowed for the first procedure and 50% for the subsequent procedures performed.

ICD-10-CM codes will help to support separate services in instances like this. The diagnosis codes for some conditions will be differentiated by site. The ICD-10-CM code set will allow us to indicate specific diagnoses associated with the specific ear as shown with these examples.

H66.3X1 Other chronic suppurative otitis media, right ear

H72.01 Central preformation of tympanic membrane, right ear

H66.012 Acute suppurative otitis media with spontaneous rupture of ear drum, left ear
Report 19342 and 11970

September 18, 2014

Question:

Over the past 15 years I have taken numerous courses taught by KZA, as has my staff. We have found you, your colleagues at KZA, and the courses all to be wonderful and very beneficial.

I was wondering if you could help me with a question I have. The last course I took with you had an emphasis on breast reconstruction coding and that was great. When a patient has an exchange of a tissue expander for a permanent implant and at the same time either a capsulectomy or a capsulotomy, I have been using 19342 instead of the 11970. I’ve thought about billing both codes – 19342 and 11970. What do you think? Any suggestions you may have will be greatly appreciated.

Answer:

Good question. The AMA’s CPT Assistant from August 2005 says: “If a temporary tissue expander has been used, it is removed after the skin has stretched sufficiently and replaced with a permanent breast prosthesis during a second operation. This procedure is generally coded 11970, Replacement of tissue expander with permanent prosthesis. Code 11970 is global and includes removal of the temporary expander, which is not to be reported separately. In certain instances, considerable capsular adjustments are necessary to allow proper placement of the prosthesis within the fibrous capsule that has formed around the expander, and with appropriate documentation in the operative report, code 19342 is sometimes used instead of 11970.” Therefore, you would never report 11970 with 19342 for a procedure on the same breast.
Control of Bleeding Same Day as a Surgical Procedure

September 4, 2014

Question:

One of our surgeons saw a patient in the office and did a surgical excision of a lesion and placed sutures. Our on-call surgeon was called to the ER later in the evening to see the patient who presented with bleeding at the site of the excision. The on-call surgeon placed a suture to control the bleeding. We follow Medicare rules for all services in the global period, but are unsure if this is billable or not because the patient returned to the ER and not our office and was seen by a different surgeon in our group.

Answer:

Thanks for your inquiry and the specifics of your question. In this scenario, the control of the bleeding, though by a different surgeon in the same group, is performed in the ER, and is considered inclusive to the excision during the global period according to the Medicare definition of the surgical package. It is considered a “complication” and did not require a return to an approved operative suite for surgical management. The services by the on-call surgeon are not separately reportable.
Anterior Spine Procedure Coding

Question:

I routinely provide exposure for a neurosurgeon doing an anterior spine procedure. After I’ve done the exposure, I leave and don’t return until he is ready to close. Is a co-surgeon modifier still appropriate or am I acting as an assistant since I wasn’t there the entire time?

Answer:

You are acting as a co-surgeon – a different specialty performing a distinct and separate part of a single CPT code. You provided the approach and closure of the CPT code. You do not have to be present for the entire surgery.

Drainage of a Postoperative Seroma

September 4, 2014

Question:

We had a patient come into the office for their postop check after a thyroidectomy and neck dissection. The doctor ended up having to drain a seroma. I sent the claim into Medicare with a 78 modifier, but it was denied as included. Did I use the wrong modifier?

Answer:
Payment for complications in the global period will depend on the payer and where the procedure or service is performed. Medicare does not allow separate payment for treatment of complications during the global period unless there is a return to the operating/procedure room (procedure room being in the hospital, such as an angiography suite or endoscopy suite). Because the seroma is a complication of the original procedure and it was drained in the office setting, it is included and isn’t separately payable by Medicare.

What Modifiers Are Necessary?

September 4, 2014

Question:

Our sports medicine surgeon performed a joint injection (20610) and ultrasound guidance (76942). What modifiers are needed to submit this code combination?

Answer:

Thanks for your inquiry. The answer is dependent on the place of service. Modifiers are not required if the service is performed in the office. Append modifier 26 to CPT code 76942 if the place of service is a Facility location.

Remember, regardless of location, a separate report is required for the professional interpretation of the ultrasound guidance.