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.

Adjacent Tissue Transfer (14xxx)

September 4, 2014

Question:

I’m reading an operative report and the surgeon says she did “undermining of the incision to close a keloid excision defect.” She wants to use an adjacent tissue transfer code. This documentation doesn’t seem to satisfy the CPT description. What do you think?

Answer:

We agree with you that the documentation is not sufficient to support an ATT code (e.g., 14xxx). “Undermining” does not constitute use of an adjacent tissue transfer code. CPT says a scar revision is reported using only a complex repair code.
Fat Graft

September 4, 2014

Question:

What code would I use for placement of a fat graft at the pituitary region?

Answer:

Good question, and this brings up an important CPT coding concept. Placement of graft material is typically included in the primary procedure code; in this example, removal of the pituitary tumor code (e.g., 61548, 62165). However, harvesting of graft material through a separate skin incision is separately reported. Harvest of abdominal fat for grafting is best reported using 20926 (Tissue grafts, other (e.g., paratenon, fat, dermis)). Why not report 15770 (Graft; derma-fat-fascia)? Because 15770 is for a composite graft which means, according to a previous CPT Assistant article, the tissue used for the graft would be “a continuous portion (containing all three of the layered components), individual parts (grafted layer by layer), or inserted in combination (such as a fascia-fat layer, later covered by a dermal layer)” – this is not what’s being done in the pituitary procedure.

Catheterization Coding

Question:
Can catheterization be reported separately with the new embolization codes?

Answer:

Yes, the new embolization codes (37241-37244) revised in 2014 exclude catheterization codes. These may be separately billed. However, the new codes do bundle the guidance and follow-up radiologic supervision codes (previously 75894/75898), but do not include diagnostic angiography when appropriately performed.

Adjacent Tissue Transfer (14xxx)

August 21, 2014

Question:
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Answer:

We agree with you that the documentation is not sufficient to support an ATT code (e.g., 14xxx). “Undermining” does not constitute use of an adjacent tissue transfer code. CPT says a scar revision is reported using only a complex repair code.

*This response is based on the best information available as of 08/21/14.*
Orders for Audiology Testing

August 21, 2014

Question:

Someone just told me that we need to have an order on the chart for audiology testing. Is this true?

Answer:

Yes, Medicare requires an order from a physician or non-physician practitioner (NPP), such as a Physician Assistant or Nurse Practitioner, to bill and be reimbursed for audiologic diagnostic testing services. These services are not covered under Medicare without an order even if a problem/condition is discovered during testing. However, Medicare does say that an audiologist may order and perform further specific testing based on the results obtained during the performance of the initially ordered diagnostic testing. Click here to access the Medicare Benefit Policy Manual.

Partial Synovectomy with Other Knee Procedures

Question:

Our surgeon performed lateral compartment meniscectomy and a medial compartment synovectomy indicating that both procedures were performed in different compartments of the knee. We billed CPT 29875 in addition to CPT code 29881 and received a
denial as inclusive. Is this correct?

**Answer:**

Yes. Code 29875, which describes limited synovectomy, has a separate procedure designation. As such, CPT code 29875 is reportable if it is the only procedure performed on the knee. [Click here](#) to refer to the AAOS Now article published in January 2013 to stay up to date on coding arthroscopic knee procedures like this. You may also plan to attend an AAOS sponsored coding course where topics such as this are covered in detailed.

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**Dog Ears**

**August 21, 2014**

**Question:**

When abdominal “dog ears” are excised after breast reconstruction surgery, is it appropriate to report the procedure with tissue rearrangement codes 14000 and 14001 when the dog ears have been excised and flaps were developed and rotated to close the wound? Or, is it more appropriate to use the excision of benign lesions codes from the 11400-11406 code series and the appropriate repair codes?

**Answer:**

First, excision of dog ears is likely considered “cosmetic” and not covered by insurance unless you can provide medical necessity for the service. If you can establish medical necessity and/or the insurance will cover it, then you would
use an excision of benign skin lesion code (e.g., 114xx) and typically an intermediate repair code (e.g., 120xx). This procedure as you’ve described it is not an appropriate use of the adjacent tissue transfer code(s).

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**Fluoroscopy**

**August 21, 2014**

**Question:**

I use intraoperative fluoroscopy to localize the disc space prior to a discectomy. Can I bill 76000 for this?

**Answer:**

Localization is included in the global surgical package and not separately reported for most neurosurgical procedure codes. It would not be appropriate to report 76000 (or any other fluoroscopy code) with codes such as a discectomy, laminectomy, fusion, etc.