FEVAR? What Is It?

Question:

My doctor is doing a FEVAR procedure. What exactly is a FEVAR?

Answer:

FEVAR, or fenestrated endovascular aortic aneurysm repair, is an endovascular approach to the repair of an abdominal aneurysm that involves the upper abdominal or visceral aorta. This mid portion of the aorta contains the celiac, superior mesenteric and renal arteries. FEVAR codes, 34841-34848, report the placement of an endograft into this section of the aorta. The endograft has fenestrations (or openings) to accommodate the visceral arteries. The codes are selected based on the number of fenestrations (1, 2, 3 or 4 openings) and the configuration of the device (the extent of the aorta involved). Please refer to your CPT manual for a detailed description of the eight new codes.

Sub-Specialty Otolaryngologists

May 29, 2014

Question:

I am new to credentialing at my clinic. We have 3 ENT doctors and a new physician joining the practice in the next few months. The new physician is a Pediatric Otolaryngologist. I am starting the initial paperwork, but can’t find a specialty code for Pediatric Otolaryngology. Should I credential him
under Pediatrics? Also, since he is a different specialty, can I bill new patient codes for any of our patients that have been seen in the practice by another physician who isn’t a pediatric otolaryngologist? The other otolaryngologists in our group refer the pediatric patients to the new physician.

Answer:

Thanks for your questions. Unfortunately, payors do not recognize the subspecialties of Otolaryngology. Even though your new doctor is a pediatric otolaryngologist, he is considered an Otolaryngologist like the rest of the physicians in your practice.

Because there is not a separate distinction for subspecialties in Otolaryngology, all physicians in the same tax ID are considered part of the same group. If a patient was evaluated by a physician of the same specialty (otolaryngology) in the same group within the last three years and is now being evaluated by your new pediatric otolaryngology physician, the service would be billed using an established visit code (9921x).

---

**Stab Phlebectomy – Less Than 10 Stabs. What To Do?**

May 29, 2014

**Question:**

I did a stab phlebectomy of 8 stabs in the right leg. I see the code 37765 is for 10-12 stabs. Does that mean I can’t use that code for 8 stabs?
Answer:

You are correct that the codes for stab phlebectomy are for the number of stabs per extremity; 37765 for 10-20 and 37766 for more than 20. If you perform less than 10, you can still bill the procedure, but you must bill it as an unlisted code, 37799. Set your fee at approximately 75% of your fee for 37765.

Cranioplasty

May 29, 2014

Question:

What is the correct code to bill for a prefabricated polymethylmethacrylate custom cranial implant greater than 5 cm? I, the neurosurgeon, think the code should be 62141 (Cranioplasty for skull defect; larger than 5 cm diameter), but the plastic surgeon who is co-surgeon on this case thinks 62143 (Replacement of bone flap or prosthetic plate of skull) should be billed. The bone flap was taken off due to infection in the global period. The custom implant was put back out of the global period.

Answer:

You are correct – the correct code for a new prefabricated cranial implant is 62140 (Cranioplasty for skull defect; up to 5 cm diameter) or 62141 depending on the diameter of the defect. If the original autologous bone flap were being replaced, then 62143 would be appropriate. Alternatively, 62143 would be appropriate if a prefabricated cranial implant were being replaced; but you would use 62140/62141 for the first-time placement of the PMMA implant.
G Code Reporting

Question:
We are a sports medicine practice (This said “patient” but that doesn’t make sense so I went with “practice.”) and frequently do chondroplasty and arthroscopic removal of foreign body procedures. Can you tell us which payers require us to report the G code?

Answer:
We cannot tell you what payors will require the G code, other than Medicare, when documentation supports the services and the G code is separately reportable. KZA recommends you survey your private payors – research private payor websites for coding guidance. Report all services according to the AMA CPT rules with the five digit CPT codes until you receive instructions in writing that the payor no longer accepts CPT code 29877 or 29874 in the presence of other arthroscopic knee procedures.

ORIF Spine Fracture Codes

May 29, 2014

Question:
When is it appropriate to use the posterior spine ORIF codes? I’ve got a patient with a degenerative pars fracture that I’m going to repair and I was looking at those codes.
Answer:

Actually, the posterior spine fracture open treatment codes, 22325-22328, should be used for treatment of traumatic spine fractures and/or dislocations rather than degenerative pathology. The spine fracture open treatment codes include any laminectomy performed at the same level(s), so you would not also bill a laminectomy code (e.g., 630xx). Look at the laminectomy for decompression codes (e.g., 630xx) for the procedure you’re planning to see if one of those codes meets your needs.

Microdermabrasion Coding

May 15, 2014

Question:

What is your recommendation for the proper CPT-4 coding for microdermabrasion? Many of my colleagues use the codes for dermabrasion (15780-15783). I have also seen unlisted codes used (17999, 96999). Thank you.

Answer:

There is not a specific CPT code for “microdermabrasion” because generally this is considered a cosmetic procedure and not billed to insurance. A CPT Assistant from December 2003 states: “Code 15783 is for “superficial” abrasion and uses the example of tattoo removal. However, tattoo pigment is embedded in the dermis and abrasion treatment of tattoo abrades into the dermis and always causes bleeding. Microdermabrasion treatment is not an epidermal procedure, nor is there an existing code that describes epidermal abrasions. The depth of injury for microdermabrasion to the epidermis is more like
that of a superficial chemical peel, such as a glycolic acid peel. Therefore, the appropriate code to report for microdermabrasion is code 17999, Unlisted procedure, skin, mucous membrane and subcutaneous tissue."

We concur with the advice to use an unlisted code if you have medical necessity and the service will be billed to insurance. But be sure to obtain written prior authorization from the payor because, as previously mentioned, it’s generally considered a cosmetic procedure.

---

**Providing Exposure for a Spine Procedure? What’s the Correct Code?**

**Question:**

I provide the retroperitoneal exposure for a neurosurgeon colleague for an anterior spine procedure. My partner went to the SVS coding course and tells me this is co-surgery. I have been billing 49010 for the exploratory laparotomy, retroperitoneal, since that is what I am doing and I have been getting paid without any problem. What is the correct coding for this situation?

**Answer:**

Your partner is correct and confirms the value of attending a coding course! The anterior spine procedure performed by the neurosurgeon, typically an anterior lumbar interbody fusion (22558), is valued for the approach, the procedure, and the closure. Therefore, you are doing a distinct part of that CPT
code and are therefore acting as a co-surgeon. Reporting 49010 is essentially double billing the approach. To code this correctly, both you and the neurosurgeon should report 22558-62 for this work.

Removal Of Nasal Pack

May 15, 2014

Question:

A patient came to the office after being seen in the emergency room with a nasal pack in place. I removed the nasal pack, but can’t figure out how to bill for taking it out. The nasal control codes only seem to be for placement.

Answer:

There isn’t a code for just removal of a nasal pack. The codes for controlling nasal hemorrhage include the necessary removal of the packs that are placed. Since there isn’t a code for removal only, you will need to report this service with either an Evaluation and Management code (e/m) or CPT 31231 if you performed a nasal endoscopy to further evaluate the nose during the visit. Depending on what occurred during the patient encounter, either of these options might be appropriate to bill for removal of nasal packs.

ICD-9-CM = 784.7 Epistaxis

ICD-10-CM = R04.0 Epistaxis
Excision of Breast Mass With Localization Wires

May 15, 2014

Question:
Our surgeon placed localization wires and then excised the breast mass. We are not sure how to report the services with the new codes. Can you advise?

Answer:
The placement of the localization wires will be found in the new codes, 19281-19288 depending on the type of image guidance. The excision of the lesion will be reported with 19125 based on the information provided.