Nipple Reconstruction

January 23, 2014

Question:

My surgeon is performing bilateral nipple reconstruction with skate flaps and full thickness skin grafts. She would like to use codes 19350 (nipple/areola reconstruction) billed on two lines with LT/RT and 59 modifiers, 15200 (full-thickness graft) on two lines with LT/RT and 59 modifiers and again 15002 (surgical preparation) on two lines with LT/RT and 59 modifiers. We are getting reimbursed for both 19350 but only one 15200 and one 15002. Are we doing something wrong? Why aren’t we getting paid for all these procedures?

Answer:

The code for nipple/areola reconstruction, CPT 19350, includes any and all procedures necessary to reconstruct the nipple/areola including harvesting and placing of grafts. Therefore, it would not be appropriate to separately report codes for grafts such as 15200. It also would not be appropriate to report a wound/scar excision code such as 15002 as this activity is included in 19350. So I would write off the charges for 15200 and 15002 and I would not separately bill these codes with 19350 in the future.

Also, 19350 accepts modifier 50 per Medicare and most payors. So it should not be necessary to use modifier 59. There are two ways to use format your claim using modifier 50:

1) Line-item format: listing the code on two separate lines and modifier 50 is appended to the second code.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Quantity</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>19350</td>
<td>Nipple/areola reconstruction</td>
<td>1 unit</td>
<td>$your single fee</td>
</tr>
<tr>
<td>19350-50</td>
<td>Nipple/areola reconstruction</td>
<td>1 unit</td>
<td>$your single fee</td>
</tr>
</tbody>
</table>
2) **Bundled format**: listing the code on one line with modifier 50 but doubling your fee

| 19350-50 | 1 unit $double your single fee |

Medicare recognizes format 2 (bundled) and will pay 150% of the single code allowable. Other payors may want format 1 (line-item).

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**Programming of Neurostimulators by Reps**

January 23, 2014

**Question:**

One of the vendor representatives comes to our office to interrogate our neurostimulators such as a deep brain stimulator and spinal stimulator. The reps keep telling my doctors that we can bill for their services “incident-to” the physician but I believe this is not right. What do you think?

**Answer:**

Trust your instincts. You are correct – it is not every appropriate to bill “incident to” the physician for something a vendor rep does such as programming a neurostimulator.
Providing Exposure More Than A Single Level Spine Procedure? What’s the Correct Code(s)?

Question:

I provide anterior exposure for a neurosurgeon colleague for an anterior spine procedure. At times, this exposure is larger to allow for a spine procedure at more than one level. The neurosurgeon’s coder indicated that I could only code co-surgeon on the primary code, 22558. Is that correct?

Answer:

CPT states that the 62 co surgery modifier is also appropriately appended to add –on codes. Therefore, as co-surgeon, if your exposure is more extensive to accommodate more than a single level anterior lumbar interbody fusion (22558), you may also report the additional levels with a 62 modifier. For example, a 2 level procedure would be reported as 22558-62 and 22585-62 for the additional level.

In-Office Audiology Diagnostic Testing On An Inpatient

January 9, 2014
**Question:**

We were asked to do an audiogram on a Medicare inpatient. The hospital does not have a booth so the patient was transported by wheelchair to our private practice office for testing. What place of service code should we use – inpatient or office?

**Answer:**

Good question. Medicare released new information about this in October 2012 and said you must use the place-of-service code that reflects the patient’s inpatient status. Therefore, you will use POS 21 (inpatient hospital). Here is the direction from the MedLearn Matters #7631 dated October 11, 2012 which was effective April 1, 2013:

“Special Considerations for Services Furnished to Registered Inpatients When a physician/practitioner furnishes services to a registered inpatient, payment is made under the PFS at the facility rate. To that end, a physician/practitioner/supplier furnishing services to a patient who is a registered inpatient, will, at a minimum, report the inpatient hospital POS code 21 irrespective of the setting where the patient actually receives the face-to-face encounter.”

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**0334T or 27096?**

January 9, 2014

**Question:**

Could you please help with some confusion that happening as a result of the alert regarding 0334T, the Category III code
that became effective for use July 1, 2013. Our doctors have been doing sacroiliac joint injections for Sacroiliitis and we have been reporting these injections as 27096 if fluoroscopic guidance is used or 20552 if fluoroscopic guidance is not used. However, now there is some question as to which code to use-27096 or 0334T.

Answer:

Thanks for your inquiry and for subscribing to the KZA Alerts! The new Category III code, 0334T describes an arthrodesis (fusion) procedure for stabilization not an injection (27096) for pain management related services. 0334T does include the term “percutaneous” but it relates to the approach for the arthrodesis. Please continue to report the SI joint injections as you have been, 27096 if fluoroscopic imaging is used; 20552 if no image guidance. Reserve reporting the Category III code, 0334T, for instances when the physician performs a SI joint arthrodesis via a minimally invasive or percutaneous approach.

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**Rib Resection with Breast Reconstruction**

January 9, 2014

**Question:**

I did a breast reconstruction with a free flap, actually a DIEP flap, and billed 19364 for the breast reconstruction as well as 21600 for the rib resection. The insurance company paid me for the breast reconstruction but denied payment on the rib resection. I appealed the denial but lost – they said that the rib resection is included in the breast
reconstruction code. Do you agree?

Answer:

Yes, we do. And, as a matter of fact, so does CPT. The CPT Assistant, July 2012 specifically states that the rib resection is included in 19364 and should not be separate reported.

Deep Brain Stimulator

January 9, 2014

Question:

One of our surgeons recently performed surgery on a patient with Parkinson’s disease. The surgery is described on the op report as follows: 1. Bilateral burr holes for implantation of subthalamic nucleus deep brain stimulation electrodes. 2. Intraoperative electrophysiologic recording and microelectrode recording. We billed 61867, 20660, 61868, 95961-26, 95962-26. The insurance company is denying payment for 20660, 95961 and 95962 (mapping/stimulation) saying the codes are inclusive. Is there any way we can get this paid?

Answer:

Actually the procedure you describe is reported using only 61867 and 61868. CPT 20660 (placement of the stereotactic head frame) is included in 61867/61868 as is the mapping/microelectrode recording (95961/95962) and all three of these codes should not have been separately reported. The payor was correct to deny them. We advise adjusting off the charges and not billing them in future cases.
### Soft Tissue Tumor Codes

**Question:**

I removed a lipoma from the chest that was a good size and pretty deep. I’m looking at the excision of benign skin lesion codes (114xx) and they just don’t seem to describe what I did. Please help.

**Answer:**

Good thing you asked for advice because new codes were introduced in 2010 that better describe the procedure you performed. Look at codes 21552 – 21556 to see which code best describes your procedure. The codes are anatomical location-specific (e.g., face/scalp, neck/anterior thorax), depth-specific (e.g., subcutaneous, subfascial), and size-based (in centimeters depending on total excision length).

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### 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.

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**Intraoperative Monitoring**

**Question:**

OK, so I now realize that I should not be billing for intraoperative monitoring based on the CPT changes for 2013. The consultants at KZA have been saying this for years and I’m now on board with you. My question is: Can I at least bill the codes 95867 or 95868 for the surgeon at the time of the surgical procedure? My doctor wants to get paid something for placing the needles.

**Answer:**

No, placing the needles is part of the procedure set up and not separately reported. It is not accurate to call it an EMG (95867, 95868).