Image Guidance with CVC Insertion

July 25, 2013

Question:

Our surgeon recently attended a coding course presented by Mary LeGrand for the College of Surgeons. Upon returning to our office, the surgeon informed us that we can report a CPT code for image guidance when he places a central line. He showed me the codes in the book. I just want to make sure that I am reading the information correctly as I have never coded the image guidance separately. I assume the radiologist would report these codes.

Answer:

Kudos to your surgeon for attending the course and sharing information learned in the course. The surgeon is correct if the surgeon is placing the CVC with fluoroscopic or ultrasound guidance. Both of the codes 77001 and 76937, are considered to be “real time” procedures thus are reportable by the surgeon when performed and the appropriate documentation is present. Please make sure to append Modifier 26, professional component only as the hospital will report the technical services.

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ER Consult

Question:

When one is called to the ER by the ER physician, and evaluates the patient, a consult code (9924x) is reportable,
even though there is a transfer of care, true?

**Answer:**

Yes this is a consult (9924x) because you went to the ER and did not know prior to that service that you would accept the patient. Remember, Medicare and many other payors do not reimburse for the consultation codes (9924x, 9925x) so you’ll have to use an alternate code.

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**Avoid a 2 % Cut to Your Medicare Reimbursement! You Only Have 5 Months Left!**

**Question:**

A colleague told me that unless I am providing quality data to Medicare by the end of this year I will see a 2% reduction in my total Medicare reimbursement in 2015. Is she right?

**Answer:**

Yes, your colleague is correct! Medicare’s Physician Quality Reporting System (PQRS), has been providing financial incentives to participants since 2007. Starting in 2015 and every year thereafter, physicians who do not participate by the end of this year will be subject to financial penalties (or as Medicare calls them “payment adjustments”). You still have 5 months to avoid this penalty by meeting minimal reporting requirements; reporting a quality measure on a single patient before December 31, 2013. To learn more about how to avoid this penalty and become part of this quality reporting system, KZA has developed a webinar with all you
Intraoperative Angiography During Microvascular Flap Surgery

Question:

I am doing this new thing during my microvascular free flap procedures where I do intraoperative fluorescent angiography (Spy) to evaluate tissue perfusion prior to closing the wound. I’m told I can bill CPT 15860 intravenous injection of agent (e.g., fluorescein) for this in addition to the microvascular free flap code. I’ve tried billing it the last couple of times but I can’t get the insurance company to pay for it. Please help.

Answer:

Anything you need to do to test the vascular flow in flap such as using a Doppler, tissue oximetry, or injecting fluorescein is included in the code for the primary procedure. Checking tissue perfusion and vascular flow is an inherent part of doing a microvascular free flap and not a separately billable procedure.
Complex Closure

Question:
One of my doctors wants to bill complex closure codes along with his breast procedure codes (i.e. breast reduction & breast reconstruction). He wants to use them for the closure stating that he is doing a complex layer closure when he closes the patient. He got the idea because he has a “friend who does this and gets paid”. Are we missing out on money because we don’t bill for the complex closure?

Answer:
No, you are not missing out. In fact, your doctor’s friend is not coding correctly. The primary closure (i.e. simple, intermediate, complex) is included in the breast reduction and breast reconstruction procedures and not separately reported.

Bilateral Fusion

Question:
Patient had posterior lumbar fusion (22612) and laminectomy w/foraminotomy and facetectomy at L4-L5 (63047) on the right and left sides. I know 63047 is unilateral or bilateral so I cannot use modifier 50 on 63047. But what about 22612? Can I bill the fusion bilaterally?

Answer:
No. The spine is considered a central structure when it pertains to the fusion codes so appending modifier 50 to 22612 is not appropriate.
Thyroidectomy and Parathyroidectomy Same Day

July 11, 2013

Question:

Our surgeon recently had a surgical procedure where the patient had a thyroid goiter and a parathyroid adenoma. Can I report both a thyroidectomy CPT code and the parathyroidectomy CPT code or are they bundled together?

Answer:

The answer to your question really lies in your scenario. You note that the patient had two disease processes necessitating the two surgical procedures, thus both procedures are reportable. You may need to append Modifier 59 to the thyroidectomy procedure if your payor has an edit in place. Make sure the surgeons note documents the preoperative pathology and any diagnostic findings in the Indication for Surgery paragraph.

Please note that the two procedures would not be separately reportable if the two separate pathologies had not been present and during the thyroidectomy, the surgeon incidentally removed a parathyroid gland. In this instance, do not use report both services and do not use Modifier 59 to inappropriately override a payor edit.
Thrombolysis Coding 2013

Question:
For the new 2013 thrombolysis codes, on the final day of therapy, can both 37211, arterial infusion for thrombolysis, and 37214, cessation of therapy, be reported?

Answer:
No, per CPT, codes 37211-37214 are reported once per date of treatment. On the final day of treatment, when the catheter is removed, the catheter removal and any imaging performed is reported as 37214.

Inferior Turbinate Submucous Resection and Outfracture

Question:
I did an inferior turbinate submucous resection removing subcutaneous tissue and bone followed by out-fracturing with the Boise elevator. Can I bill 30140 for the submucous resection and 30930 for the out-fracture?

Answer:
Actually, CPT specifically says “Do not report 30801, 30802, 30930 in conjunction with 30130 or 30140.” Therefore, it would not be appropriate to report 30140 and 30930 on the same turbinate. CPT 30930 may be reported when you do an out-fracture alone.
Excision of Melanoma

Question:
I've heard differing advice and hope you will clear up something for me. What CPT code do we use for excision of a melanoma? I've heard people say to use the excision of skin lesion code, 116xx, and others tell me to use the soft tissue or radical excision of tumor codes such as 21556 or 21557?

Answer:
Good question. CPT says that a melanoma is a cutaneous lesion and, therefore, an excision/resection should be reported using the excision of malignant skin lesion codes such as the 116xx codes. It is not accurate to report an excision of soft tissue tumor code (e.g., 21555, 21556) or radical resection of soft tissue tumor (e.g., 21557) code for excision of a melanoma.