Excisional Biopsy

January 19, 2017

Question:
My doctor’s documentation for a biopsy indicates he performed an “excisional biopsy of the skin”. Is this correct?

Answer:
No, CPT does not have a code for excisional biopsy. It is either a biopsy (11100 or 11101) or a benign or malignant excision code. (114xx, 116xx). It is important to use the appropriate terminology in the documentation to make it clear what type of procedure is performed. It is important to remember that all excision codes include a biopsy.

*This response is based on the best information available as of 01/19/17.

Cosmetic Closure After Spine Surgery

January 5, 2017

Question:
My friend the spine surgeon asked for my help on an upcoming case. It is a two-level anterior cervical discectomy and fusion where the patient requested a plastic surgeon to make the incision and do a cosmetic closure. I checked with his billing office and the codes for the case are 22551, +22552, +22845, and +20931. Am I a co-surgeon (modifier 62) on all the
same codes because I’m doing the incision and closure?

**Answer:**
Actually, you should not bill anything to insurance. The incision and usual closure are included in the primary procedure code, 22551. If the patient wants a “cosmetic” result then this is cash from the patient and it should not be billed to insurance.

*This response is based on the best information available as of 01/05/17.*

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**Diagnosis for Open Wounds as a Result of Cancer Resection**

December 15, 2016

**Question:**
What diagnosis code do we use when we are reconstructing a defect after the Moh’s surgeon, or someone else removed the cancer? When I try to crosswalk the ICD-9-CM open wound code I used to something in ICD-10-CM, it takes me to an S code which is strange because the open wound is not the result of an injury or trauma.

**Answer:**
Good question! Technically, you would not use a cancer diagnosis code since you are not treating cancer (the Moh’s surgeon treated the cancer by excising it). Your diagnosis codes, as the surgeon treating an open wound/resulting defect
resulting from cancer resection are:

1. Z48.1 Encounter for planned postprocedural wound closure, and
2. Z42.8 Encounter for other plastic and reconstructive surgery following medical procedure, and
3. Personal history of neoplasm code (e.g., skin Z85.82-, melanoma Z85.820). If the reconstruction occurs on the same day as the cancer removal, then the C code for malignant neoplasm can be substituted for the Z85.- code.

*This response is based on the best information available as of 12/15/16.

Bilateral Nasal Vestibular Stenosis/Valve Repair

November 17, 2016

Question:
I’ve been billing 30465 and 30465-50 for bilateral. I’m having a hard time getting paid on the second side (30465-50). Should I use modifier 59 instead of modifier 50?

Answer:
No! CPT guidelines state to use modifier 52 (reduced services) on 30465 if only one side is corrected. Therefore, 30465 implies both sides were surgically corrected and it would be inappropriate to append modifier 50 (bilateral procedure).
Removal of Mandibular Interdental Fixation

October 27, 2016

Question:
We did a mandibular fracture repair on a patient (car accident) and placed the interdental fixation as part of the fracture repair. We saw the patient in the office, about 8 weeks postop, for a visit and everything was looking good so we removed the wires/fixation. Is the removal separately billable or included in the global fee?

Answer:
Good question! The removal of the interdental mandibular fixation (IMF) is included in the global period when performed in the office setting. If you think about it, you put the IMF on so it is up to you to take it off.

*This response is based on the best information available as of 10/27/16.*
**Endoscopic Septoplasty**

October 13, 2016

**Question:**
Is there a code for an endoscopic septoplasty?

**Answer:**
There is not a separate code for an endoscopic septoplasty nor is there an add-on code for the endoscope. You’ll use 30520, the usual septoplasty code.

*This response is based on the best information available as of 10/13/16.*

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**Capsulectomy and Revision of Breast Reconstruction**

September 29, 2016

**Question:**
My doctor did a partial capsulectomy to revise the inframammary fold as well as fat grafting to some defects on a reconstructed breast. Additionally, he revised the scar and took off some excess lateral breast tissue. We submitted the following codes: 19380, 19371-59, 20926-59, and 15839-59. We only got paid on 19380. I have appealed the denial twice but no luck. Can you please help?
**Answer:**
Sorry – can’t help! Actually, all the procedures you performed are covered in one code, 19380 (Revision of reconstructed breast).

*This response is based on the best information available as of 09/29/16.*

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**Reimbursement:Assistant Surgeon**

September 15, 2016

**Question:**
What is the reimbursement for an assistant surgeon using modifier 80? Is the payment different for the primary and the assistant?

**Answer:**
Assistant surgeon is described as one surgeon, of the same or a different specialty, providing assistance during a surgical procedure or CPT code. Modifier 80 (modifier 82 for an assistant surgeon in an academic setting when a qualified resident is not available) is appended to any CPT code the assistant participates in. Medicare reimburses 16% of the allowable for the assistant surgeon (modifier 80 or 82), to the codes where an assistant payment is allowed, and multiple procedure/bilateral procedure reductions also apply. The primary surgeon’s fee is not affected. In an assistant surgeon scenario, the assistant need not and should not dictate a separate note. However, it is critical that the primary
surgeon document in his/her note, specifically what the assistant did. Stating an assistant was needed because the case was complex is not sufficient. The primary surgeon must state what the assistant did, for example, assisting with the resection, anastomosis, etc. For private payers, coding guidelines and payment may vary.

*This response is based on the best information available as of 09/15/16.

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Reimbursement: Co-Surgery

September 1, 2016

**Question:**
What is the reimbursement for co-surgery using modifier 62? Is it different for the primary and co-surgeon?

**Answer:**
For Medicare, co-surgery requires two different specialties performing separate parts of a single CPT code. For both surgeons, modifier 62 is appended to the appropriate CPT code(s). Medicare multiples the allowable by 125% and splits the reimbursement exactly in half, resulting in a payment of 62.5% to each surgeon. For example, when plastic surgery and neurosurgery do a craniosynostosis procedure together using 61559 then each surgeon reports 61559-62. So to answer your question, the payment is the same for both surgeons. Both surgeons dictate an operative note describing their work and both have post-operative responsibilities. For private payers, coding guidelines and payment may vary.
Surgical Modifiers: How Do They Impact Reimbursement?

August 18, 2016

Question:
What reimbursement should we expect when using the global period modifiers 58, 79 and 78?

Answer:
Surgical modifiers are used to indicate that a subsequent procedure was performed during the global period of a prior surgery. Modifiers tell the payer the rationale for allowing payment for this subsequent procedure. The modifiers and reimbursement impact of each is shown below:

Modifier 58: to indicate a second procedure was performed as a staged procedure. Reimbursement should be 100% of the allowable fee.

Modifier 79: To indicate an unrelated procedure was performed during the global period of the original procedure. Reimbursement should be 100% of the allowable fee.

Modifiers 78: To indicate that a complication of an original procedure was treated by a return to the operating room, catheterization or endoscopy suite. Reimbursement should be at 70-80% of the allowable fee. This reduction reimburses for the intra-operative portion of the procedure only, since the
patients pre and post-operative services are paid under the original surgery’s flat fee.

*This response is based on the best information available as of 08/18/16.

Look for an upcoming KZA Webinar on “Modifiers for surgeons: What you need to know”, which will cover modifiers 22, 59, 58, 79 and 78.

Also stay tuned for another KZA webinar “Surgeon Role Modifiers. Co-surgeon, assistant Surgeon, or coding separate codes: current coding and documentation Guidelines.