When coding for an EVAR, I have a difficult, even impossible time determining if the surgeon places and extension, or if the “limb” she is placing is part of the device. Any help?

You are not alone in this dilemma! The first step is to understand the configuration of the devices, in particular the ones your surgeon is using. For example, code 38402 is for a modular bifurcated device, which means it has a main body with an attached limb, along with a separate modular limb intended to be placed on the opposite side. If this modular piece is attached, surgeons will often document it as an extension. However, it should not be billed as an extension (34825) since it is part of the device. Knowing the brand names of the devices can help you match the device to a code. I recommend working with your surgeon to list the brand of device(s) she uses and match each with a code. This will be helpful in determining when a limb placement is part of the device and when it is a true extension. Also stay tuned for revisions of these codes possibly in 2018.

Please join us in Chicago on October 21-22, 2016 for the SVS sponsored Vascular Coding course with KZA consultant Teri Romano as a faculty member. Can’t make the October course or have too large a staff for all to attend? Contact KZA for an intensive and interactive vascular coding course at your location.

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

September 29, 2016

Question:
I am continually confused by the AV access codes, in particular, the percutaneous codes. I have one specific question. Does code 36147 include all imaging, venous and arterial?

Answer:
Yes, the entire range of venous access codes are very confusing and complex! Code 36147 is an all-inclusive code and includes all venous imaging from the venous side of the access to and including the right atrium. In terms of arterial, 36147 includes the area of the arterial anastomosis, what CPT describes as the peri-anastomotic site. If it is clinical necessary (and documented as such) to image areas distal from the arterial anastomosis; the entire extremity for example, an extremity arteriogram may be reported.

It’s important to note that these codes may be revised in 2017. Watch for a KZA webinar in November/December of 2016, “2017 Update in Vascular Coding”.

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Is It Co-surgery or Not?

September 15, 2016

**Question:**
I was asked by a urologist to clear a vena cava thrombus during his patient’s nephrectomy for a malignancy. I was able to dissect the malignancy from the vena cava without any reconstruction. I think I should bill for my work separately from the urologist. My coders disagree. How is this billed?

**Answer:**
Thank you for your question. In the Society of Vascular Surgeons (SVS) Coding course we discuss numerous scenarios where more than one surgeon participates in a surgery. In your scenario, CPT code 50230 describes a nephrectomy, radical with regional lymphadenectomy and/or vena cava thrombectomy. In this case, two surgeons with different skill sets and specialties perform distinct parts of this single CPT code. This is classic co-surgery. You will report 50230 with a 62 modifier and the urologist will report 50230 with a 62 modifier.

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New Patients and NPs

September 1, 2016

Question:
Our office-based NP usually sees established patients with established problems, and the supervising physician is onsite. What should we do if the NP sees a new patient or a returning patient has a new problem?

Answer:
The practice has two options. First, the NP could simply bill that visit using the direct method (under the NP’s name). Alternately, a physician could see the new patient to set the plan of care, with the visit reported by the physician. Remember, for a new patient or new problem seen in the office setting, the physician cannot use the documentation elements already captured by the NP; code assignment would be based only on the work the physician performs and documents.

*This response is based on the best information available as of 09/01/16.*
**Reimbursement: Co-surgery**

August 18, 2016

**Question:**
What is the reimbursement for co-surgery? 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, a 62 modifier is appended to the appropriate CPT code(s). Medicare multiples the allowable fee by 125% and splits the reimbursement exactly in half, resulting in a payment of 62.5% to each surgeon. Both surgeons dictate an operative note describing their work and both have post-operative responsibilities.

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

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**Vena Cava Coding**

August 4, 2016

**Question:**
While placing a vena cava filter, the physician documented a venogram and intravascular ultrasound. Can these imaging procedures be reported separately?

**Answer:**
No, vena cava filter placement, 37191, is an all inclusive
code that includes all imaging including a venogram and intravascular ultrasound (IVUS) codes, 37252 and 37253. Vena cava filter placement also includes all access including the catheterization.

*This response is based on the best information available as of 08/04/16.

New vs. Established Patient

July 21, 2016

**Question:**
If I see a new patient and during that visit I identify the need for surgery the same day, can I append a Modifier 57 to the E/M service and get paid?

**Answer:**
You determine during the evaluation that the patient would need surgery the same or next day for a major procedure (90 day global), append Modifier 57 to the E/M service. We are seeing denials from various payers when reporting Modifier 57 particularly when the patient is evaluated in the emergency department. You may need to appeal any claim denials as CPT guidelines allow the use of Modifier 57.

If the procedure is a minor procedure with at 10 day global and the E/M service is **significantly separately identifiable**, report the E/M service with Modifier 25.

Use caution when appending the 25 Modifier as CMS has indicated that there is an inherent E/M service in every procedure and routine use of Modifier 25 may create payer
Vena Cava Coding

July 7, 2016

Question:
While placing a vena cava filter, the physician documented a venogram and intravascular ultrasound. Can these imaging procedures be reported separately?

Answer:
No, vena cava filter placement, 37191, is an all inclusive code that includes all imaging including a venogram and intravascular ultrasound (IVUS) codes, 37252 and 37253. Vena cava filter placement also includes all access including the catheterization.

*This response is based on the best information available as of 07/07/16.*
Source for a Consult

June 23, 2016

Question:
What is an appropriate “source” for a consult? I asked at a recent workshop and the instructors did not have an answer.

Answer:
The guidelines for a consultation (inpatient or outpatient) must be requested by a physician, or qualified non-physician practitioner. Guidelines are not clear regarding individuals who may be considered an appropriate source, but some likely examples include a physician assistant, nurse practitioner, doctor of chiropractic, physical therapist, occupational therapist, speech language therapist, psychologist, social worker, lawyer, or insurance company.

Do not report a consultation requested by a patient or family member, etc., using a consultation code.

*This response is based on the best information available as of 06/23/16.

Coding Modifier 57 with E/M Visits

June 9, 2016

Question:
If I see a patient and during an E/M visit where I identify the need for surgery the same day, can I append a Modifier 57 to the E/M service and get paid for that E/M service?
Answer:
Yes, if you determine during the evaluation that the patient requires surgery the same or next day for a major procedure (90 day global) and append Modifier 57 to the E/M service. This should allow payment for that “decision for surgery” E/M. However, that being said, we are seeing denials from various payers when reporting Modifier 57, particularly when the patient is evaluated in the emergency department. You may need to appeal any claim denials as CPT guidelines allow the use of Modifier 57.

*This response is based on the best information available as of 06/09/16.*