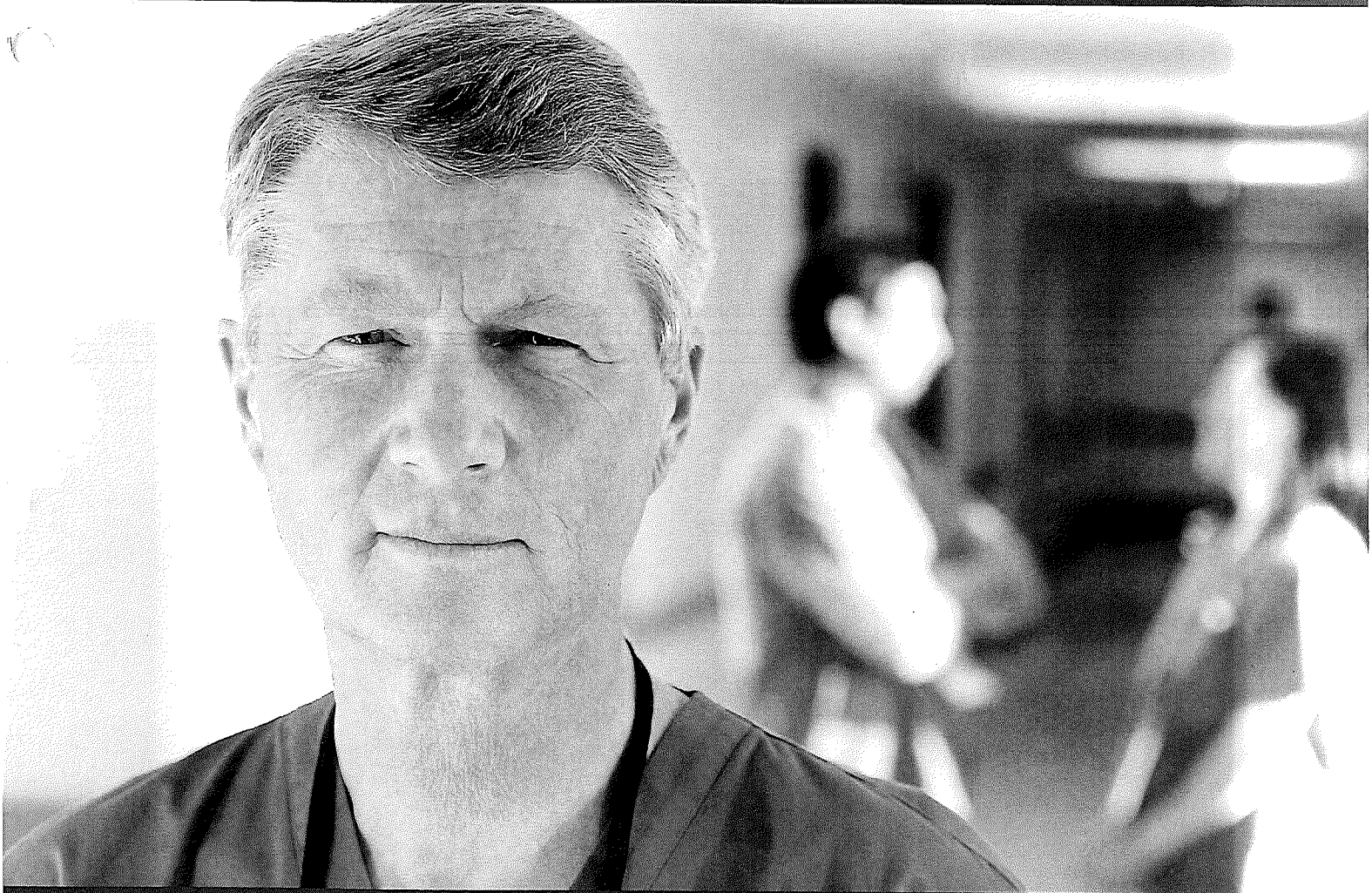


cpt[®] Assistant

Your practical guide to current coding

December 2009 / Volume 19 Issue 12



Page 3
Coding Brief:
Special EEG Tests

Page 4
Coding Clarification:
Ureterotomy
(Code 50605)

Page 6
Continuous Glucose
Monitoring

Page 9
CPT Assistant: Bonus
Feature: Special Q&A

- Maintenance of sedation
- Monitoring of oxygen saturation, heart rate, and blood pressure
- Recovery (not included in intraservice time)

Surgery: Cardiovascular System

Question: Can code 36593 be reported more than once per day for declotting of a central venous access device or catheter?

Ann Waters, RHIT, CCS

Answer: Yes. In the event declotting of the central venous access device or catheter is required more than once per day, code 36593, *Declotting by thrombolytic agent of implanted vascular access device or catheter*, can be reported with the modifier 59, *Distinct procedural service*, appended. Declotting of a partially or completely implanted device or catheter may necessitate the use of a thrombolytic agent (eg, Urokinase), which is introduced through a syringe and then slowly instilled into the device or catheter. This code is not to be used for routine flushing of vascular access devices with saline or heparin. This type of flushing is considered inclusive in chemotherapy services, and is not separately reported. Code 36953 should not be reported multiple times for each sequential administration of thrombolytic (tPA) during the same episode. It should only be used multiple times when defined separate declots take place.

Question: What code would be reported to describe insertion of non-tunneled centrally inserted central venous access device with subcutaneous port? Codes 36560-36561 are defined as tunneled. At times the documentation reflects insertion of a CV catheter directly into a central vein with a subcutaneous port, but without the mention of tunneling. **Sharon Gilbert**

Answer: An implanted subcutaneous port with an attached central catheter is described by either code 36560, *Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; younger than 5 years of age*, or code 36561, *Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; age 5 years or older*. Although the procedure report may not state *tunneled* or *non-tunneled*, it is not procedurally possible to insert a catheter with a port attached in a manner that is not *tunneled*.

As indicated in the guidelines for the Central Venous Access Procedures subsection of the CPT codebook, "The venous access device may be either *centrally* inserted (jugular, subclavian, femoral vein or inferior vena cava catheter entry site) or *peripherally* inserted (eg, basilic or cephalic vein). The device may be accessed for use either via exposed catheter (external to the skin), via a subcutaneous port or via a subcutaneous pump." (CPT 2010, p193)

Codes 36560 and 36561 involve creation of a subcutaneous pocket for placement of a completely implanted central venous access port with the catheter being *tunneled* from the vein of choice through the subcutaneous tissue to the implanted central venous device. The central venous catheter is then internally connected to the port device.

To distinguish physician work, codes 36570, *Insertion of peripherally inserted central venous access device, with subcutaneous port; under 5 years of age*, and code 36571, *Insertion of peripherally inserted central venous access device, with subcutaneous port; age 5 years or older*, also involve creation of a subcutaneous pocket for placement of a completely implanted central venous access device, but these catheters are placed in an extremity vein instead of a vein in the chest wall or neck. To illustrate, a guidewire is inserted by puncturing the basilic vein (in the arm) and centrally passed through the vein. A subcutaneous pocket is then created in the arm to implant the port device. The central venous catheter is measured to length, placed, and connected to the port device.

Surgery: Digestive System

Question: When performing an open repair of a parastomal hernia, colostomy is freed and mobilized, but not revised or moved to a different site. Is it necessary to append Modifier 52 in order to report code 44346? **Carolyn M. Roberts, CCS, CCS-P, CPC, CPC-I**

Answer: No. It is not necessary to append the reduced services Modifier 52 to report code 44346, *Revision of colostomy; with repair of paracolostomy hernia (separate procedure)*, as "freeing and mobilization" of the colostomy stoma is inherent in parastomal hernia repair.

Surgery: Nervous System

Question: Should code 64640 x4 be reported per lesion because it is a single percutaneous entry point or should the unlisted code 64999 be reported? What is the appropriate code to use for radiofrequency (eg, Simplicity III™ Radiofrequency Probe) for sacroiliac (SI) joint nerve destruction from a single percutaneous entry site in the following procedure?

The Simplicity III electrode was then advanced, maintaining continuous contact with the sacrum, on a cephalad and slightly lateral line, staying lateral to the sacral foramen, medial to the sacroiliac joint, and ventral to the ilium, until contact with the sacral ala prevented further advancement. Appropriate positioning was confirmed by changing the caudal/cephalad tilt of the C-arm to parallel the superior endplate of S1; and verifying once again that the entire length of the Simplicity III electrode was advanced to the ipsilateral sacral ala and the three independent, active contacts

were positioned adjacent to the S1, S2, S3, and S4 lateral branch innervation pathways... "Lesioning" was then carried out using the Simplicity III preprogrammed protocol at 85 degrees centigrade for five minutes.

Karen Glancy, CCS-P

Answer: Since the documentation indicates insertion of a single electrode (having three contacts) at the sacroiliac (SI) joint "to lesion the lateral branches of S1, S2, S3, and S4," code 64999, *Unlisted procedure, nervous system*, is reported *once*. This "SI joint rhizotomy" would be reported *once* using the unlisted nervous system code 64999. The sacroiliac (SI) joint and sacral anatomy differs in that it is comprised of spine bone and pelvic bone wherein the exact innervation of the SI joint occurring more from contributing branches at adjoining nerve levels. Procedurally, the work of the described SI joint destruction differs from that described by code 64622, *Destruction by neurolytic agent, paravertebral facet joint nerve; lumbar or sacral, single level*. Code 64622 may be reported for L5-S1 rhizotomy (nerve destruction since this joint lies between two spinal segments for which the anatomy and procedural work at L5-S1 is similar to that at other spinal segments (eg, L4-5). Therefore, the unlisted nervous system code 64999 would be reported once for SI joint or sacral rhizotomy (nerve destruction).

12

To differentiate between the work when performing sacral nerve destruction of S1, S2, S3, and S4, each individually separate peripheral nerve root neurolytic block is reported as destruction of a peripheral nerve, using code 64640, *Destruction by neurolytic agent; other peripheral nerve or branch*. In this instance, code 64640 is reported four times. It is suggested that Modifier 59, *Distinct Procedural Service*, be appended as well.

It is very important that the service performed matches accurately with the description in the CPT code. Therefore, for this very reason, it is important to remember that a code that is "close" to the procedure performed is *not* selected in lieu of an unlisted code. There are some who maintain that they are not allowed to use unlisted codes or that the use of the unlisted codes is undesirable. While the use of an unlisted procedure code *does* require a special report or documentation to describe the service, correct coding demands that you use a code that is appropriate for the service being provided (ie, a code that most accurately represents the services rendered and performed).

Surgery: Urinary System

Question: Can code 77002 be used in conjunction with code 52332, Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type), when the surgeon is placing a guide wire in the ureter for eventual place-

ment of an indwelling ureteral stent? In the code descriptor of code 77002, what does the term "localization device" apply to?

Rachel H. Phillips

Answer: No. Since fluoroscopy is included with all the cystourethroscopy codes, a separate fluoroscopy code (77002) would not be reported when used in conjunction with cystourethroscopy. Also, code 77002 would not be reported for the insertion of a guidewire as this is an intraprocedural step in the placement of the indwelling ureteral stent (code 52332). Insertion of an indwelling or nontemporary stent (code 52332) involves the placement of a specialized self-retaining stent (eg, J stent) into the ureter to relieve obstruction or treat ureteral injury. This requires a guidewire to position the stent within the kidney. The ends of the stent are coiled so that one end is anchored in the renal pelvis while the other is in the bladder, thereby preventing migration. In contrast, temporary ureteral catheters are open-ended straight tubes that are placed within the ureter to perform retrograde pyelography or to collect selective ureteral urine for cytologies.

A localization device is a type of fiducial marker used to identify a lesion that will subsequently be treated either with surgery or radiation therapy. One example is using fluoroscopy to immediately place an opaque skin marker over a lesion, such as a bone tumor in a rib to mark the location for surgical biopsy. Another is the use of an opaque "washer" over a joint to mark a point of insertion of a needle for aspiration/injection.

Surgery: Eye and Ocular Adnexa

Question: When a rust ring is removed from the cornea by scraping or using a drill (burr) at the time of foreign body removal, is it appropriate to report both codes 65222, Removal of foreign body, external eye; corneal, with slit lamp, and 65435, Removal of corneal epithelium; with or without chemocauterization (abrasion, curettage)? Donna Allshire, CPC, CPC-H, CPC-I, CEDC, RCC

Answer: The removal of rust ring on the same day as the corneal foreign body removal is considered an inclusive component of the procedure, and therefore, should not be reported in addition with code 65222 *Removal of foreign body, external eye; corneal, with slit lamp*. However, if another procedure, eg, epithelium removal, is performed on a second or subsequent day, this procedure would include the rust ring removal, and can therefore, be reported using code 65435, *Removal of corneal epithelium; with or without chemocauterization (abrasion, curettage)*.

Question: Can code 65435, Removal of corneal epithelium; with or without chemocauterization (abrasion, curettage),