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Part B Insider (Multispecialty) Coding Alert

Skull Base Surgery: Can You Code for Two Approaches in One Surgery?

Find out what the other surgeon billed before you start coding

Billing for approaches to the skull base can make you feel as if you're "trying to fit a square peg into a round code," says **Eric Sandham**, compliance educator with Central California Faculty Medical Group, Fresno. The complexity of these procedures and the collaboration between surgeons make it important to get all the facts before coding.

Skull base surgery (CPT Codes 61580-61619) is an area of tremendous complexity, and the possibilities for confusion are immense. The fast-growing procedure treats lesions at the base of the skull.

"This is the only place in CPT where approach and closure is not bundled into the service," says **Marcella Bucknam**, HIM coordinator with Clarkson College in Omaha, Neb. These surgeries often involve a neurosurgeon collaborating with an ENT and possibly a plastic surgeon.

In fact, the CPT includes 14 codes for approach in skull base, 61580-61598. Nevertheless, some coders feel as though none of these codes may adequately describe the work the surgeon performed, Sandham says.

Sometimes, a surgeon will perform a more extensive approach involving two different types, and there's no guidance on whether the surgeon can combine two approach codes, Sandham says. "There may be some times when there's overlap in the procedures from two different descriptions. Personally, I think if the physician has done the approach that is described by two complete but separate approach codes, he should bill for both."

"One of the biggest mistakes that's made is possibly not coding for the approach at all or to the full extent," says **Pat Boudreaux**, data specialist with Tyler Neurosurgical Associates in Tyler, Texas. "You can have basically two approaches. A lot of times they end up going from two different angles."

"I have not heard that you can code more than one approach," Bucknam says. Often, there's a code that adequately describes the approach performed, but it doesn't reimburse well enough to satisfy the surgeon. This is just one of a few areas where Bucknam believes surgeons try to overbill.

Another area of controversy: The CPT guidelines are very specific that you can add only one add-on code for transection or ligation of the carotid artery (61609-61612) in addition to primary procedure codes 61605-61608. But surgeons frequently want to bill for more than one add-on code, Bucknam says.

Modifier -22 (Unusual procedural services) "is your friend on this stuff if you feel you're doing a lot more" than the code normally describes, Bucknam says.

One problem ENT surgeons will have is that they actually perform both the approach (61580-61598) and the closure (61618-61619) of the skull base, but the CPT guidelines state that the closure can't be billed separately unless they're using "extensive dural grafting, cranioplasty, local or regional myocutaneous pedicle flaps, or extensive skin grafts" for the closure. So the closure is bundled with the definitive procedure, for which the ENT isn't getting paid. It may be possible to negotiate with the neurosurgeon for extra reimbursement to cover this portion of the procedure.

Both neurosurgeons and ENTs complain that they're not compensated adequately for these procedures, because they must share reimbursement. Worse still is when the skull base surgery codes don't describe one of the services they've performed, and they end up having to use one of the craniotomy or craniectomy codes (61304-61576) with modifier -62 (Two surgeons), Bucknam says.

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Another problem is that sometimes the ENT wants to code for an approach that doesn't fit with the definitive procedures the neurosurgeon billed for, Bucknam says. If the ENT tries to bill for an anterior approach, but the neurosurgeon is billing for a middle cranial fossa procedure, then the ENT will receive a denial.

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