Post-Op hemorrhage repair. Is it billable?

September 7, 2017

Question:
Can I bill for taking the patient back to the OR to explore and repair post-op hemorrhage on day post-op? I heard that all complications are included in the payment of the original surgery.

Answer:
Yes, you may bill for this. CPT and Medicare agree that taking the patient back to the OR to treat a complication is billable. A modifier 78, unplanned return to the OR) is appended to the procedures performed to treat the hemorrhage. The appropriate ICD-10 code for a postoperative hemorrhage would also be reported.

*This response is based on the best information available as of 09/07/17.

Global Period for Surgery. Is it billable?

September 7, 2017

Question:
My patient presented to the ED with an infection at the incision site from a surgery that I did 4 weeks ago. It has a
90 day global. I was on vacation so my general surgeon partner saw the patient and admitted her. What should she bill for this?

**Answer:**
Since the patient is in a global period for the surgery, this is not billable, by you or any of your partners of the same specialty.

From a billing perspective, you and your partners are a single billing entity. Therefore, you all share the global package.

*This response is based on the best information available as of 09/07/17.*

**Assistant Surgeon Payments**

September 7, 2017

**Question:**
We are seeing payors ask for payment back when we use Modifier 80 for assistant surgeon. Is there a reason why they would take the payment back?

**Answer:**
We are seeing payors including Medicare and Medicaid ask for payment recovery when the documentation does not explain what role the assistant played in the surgery. It is not enough to state that the procedure was complex. Specifics of what the assistant did, assisted with the resection and anastomosis for example, must be documented to support billing for an assistant surgeon.
Billing Medicare Patient Admittance

September 7, 2017

Question:
I was consulted to see a Medicare patient in the emergency room (ER) by the Emergency Department physician. When I arrived, the patient was still in the ER but had been admitted to the hospitalist and was waiting for a bed.

Answer:
Since the patient is Medicare and has been formally admitted you would report CPT codes 99221-99223 for this consultation service, even though the patient is physically in the ED. Keep in mind Medicare does not pay for inpatient or outpatient consultations.

*This response is based on the best information available as of 09/07/17.
Assistant Surgeon Payments

August 24, 2017

Question:
We are seeing payers ask for payment back when we use Modifier 80 for assistant surgeon. Is there a reason why they would take the payment back?

Answer:
We are seeing many payers including Medicare and Medicaid ask for payment recovery when the documentation does not explain what role the assistant played in the surgery. It is not enough just to identify that the patient encounter is complex but actual detail of what the assistant did during the surgery can support billing for an assistant surgeon.

*This response is based on the best information available as of 08/24/17.

Billing for Pre-Op H&P Visit

August 24, 2017

Question:
Hospitals require that we do an H&P within 30 days of taking a patient to the OR. If this visit is more than 48 hours prior to surgery, is that a billable visit?

Answer:
No, the H&P in this case is not a billable visit. This question comes up often and was addressed by AMA CPT Assistant
in the following excerpt:

“If the decision for surgery occurs the day of or before the major procedure and includes the preoperative evaluation and management (E/M) services, then this visit is separately reportable. Modifier 57, Decision for Surgery, is appended to the E/M code to indicate this is the decision-making service, not the history and physical (H&P) alone. If the surgeon sees the patient and makes a decision for surgery and then the patient returns for a visit where the intent of the visit is the preoperative H&P, and this service occurs in the interval between the decision-making visit and the day of surgery, regardless of when the visit occurs (1 day, 3 days or 2 weeks) the visit is not separately billable as it is included in the surgical package. Example: The surgeon sees the patient on March 1 and makes a decision for surgery. Surgery is scheduled for April 1. The patient returns to the office on March 27 for the H&P, consent signing, and to ask and clarify additional questions. The visit on March 27 is not billable, as it is the preoperative H&P visit and is included in the surgical package.”

Source: AMA CPT Assistant, May 2008/Volume 19, Issue 5, pp. 9, 11

CPT says once the decision is made to proceed with surgery the subsequent visits related to the procedure (e.g., doing H&P, getting consent form signed, answering questions) are included. However, in some cases a patient may be a candidate for a surgical procedure but has a number of medical issues (such as cardiac disease and asthma) that require a medical evaluation to determine if he/she is healthy enough for surgery. After the patient has had a “medical clearance” he/she returns to you to review the medical doctor’s evaluation and you at that point decide to proceed with surgery. This visit can be billed as an E&M visit as the decision for surgery is just now being made.
Paramedian Forehead Flap on Previous Mohs Surgery

August 24, 2017

Question:
My doctor did a division and inset of a paramedian forehead flap on a patient that had Mohs surgery on their nose. Do I code 15620 since the flap was brought from the forehead, or 15630 since the flap was placed on the nose?

Answer:
Good question. If you look at the code descriptors, they state, “Delay of flap or sectioning of flap at...” This means that the code is chosen for where the flap is inset. In your case, the flap was inset at the nose. CPT code 15630 for division and inset at the eyelids, nose, ears, or lips, would be the correct code to report. Don’t forget also that if repair of the donor site requires skin graft or local flap to repair, it is separately reportable. Hope this helps.

*This response is based on the best information available as of 08/24/17.*
How do I know if co-surgeon will be paid? What about assistant surgeon?

August 24, 2017

Question:
How do I find out if an assistant surgeon or co-surgeon is paid on certain procedures that I perform?

Answer:
This information is published by Medicare on the Medicare website.

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup/index.html

You can also google “Physician Fee Schedule Look up” to access the site. Once there, you can enter a single or up to four CPT codes. Follow the prompts and indicate your search is for “payment policy indicators” (see the search choices below, Table 2). The search will show the codes and several policies, including numbers (see table 3), 0, 1, 2, 9 that indicate the payment status of the code. Table 4, tells you what those codes mean; paid, paid with documentation or not paid.

Table 1
Table 2
Table 3
Table 4 Policy indicators

<table>
<thead>
<tr>
<th></th>
<th>Co-Surgeon (62)</th>
<th>Assistant Surgeon (80-82)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Co-surgeon not permitted</td>
<td>0 = Paid with documentation</td>
</tr>
<tr>
<td>1</td>
<td>Paid with documentation</td>
<td>1 = Not paid</td>
</tr>
<tr>
<td>2</td>
<td>Paid with two specialties</td>
<td>2 = Paid</td>
</tr>
<tr>
<td>9</td>
<td>Concept does not apply</td>
<td>9 = Concept does not apply</td>
</tr>
</tbody>
</table>

*This response is based on the best information available as of 08/24/17.*
Moderate sedation Denials. How do we get paid for 99153?

August 24, 2017

Question:
We are billing the new moderate sedation codes, but are getting denied on the second 15 minutes, 99153. Almost all our patients have sedation for more than 15 minutes. What are we doing wrong?

Answer:
You are doing nothing wrong! The codes you are referencing are listed below. Code 99151 or 99152 are paid without a problem. It’s code 99153 that is the issue. When Medicare valued these new codes as part of the Medicare Physician Fee Schedule, 99152 (or G0500 for GI endoscopy procedures) had an RVU assigned. Code 99153, for the second 15 minutes, (or a minimum of 23 minutes total of sedation) did not have a professional fee value assigned, indicating that Medicare will not pay for these additional minutes. Medicare considers all physician work for moderate sedation to be covered by the single code; 99151 (or G0500 for GI endoscopy procedures). Continue to bill per CPT guidelines that allow this second code. Private payors may pay for this code. Write off the Medicare denial.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>99151</td>
<td>Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status; initial 15 minutes of intra-service time, patient younger than 5 years of age</td>
</tr>
<tr>
<td>99152</td>
<td>initial 15 minutes of intra-service time, patient age 5 years or older</td>
</tr>
<tr>
<td>+99153</td>
<td>each additional 15 minutes intra-service time (List separately in addition to code for primary service)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0500</td>
<td>Moderate sedation services provided by the same physician or other qualified health care professional performing a gastrointestinal endoscopic service that sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status; initial 15 minutes of intra-service time, patient age 5 years or older. Report additional time with 99153 as appropriate Use only for GI endoscopy procedures for Medicare patients</td>
</tr>
</tbody>
</table>

*This response is based on the best information available as of 08/24/17.*
Navigation x 2?

August 24, 2017

Question:
I’ve got an upcoming case where I’m removing two different brain tumors and I’ll be using neuronavigation (+61781). Since I have to make 2 plans, register the coordinates twice, and plan 2 separate trajectories, can I report +61781 twice (+61781, +61781-59 or +61781 x 2 units)?

Answer:
No. The CPT Assistant, September 2011 indicates that the navigation code is reported once per operative session.

*This response is based on the best information available as of 08/24/17.*