Transitional Care Management Codes

May 12, 2016

Question:
We’ve been using the transitional care management codes, 99495-99496, for post-op discharge care (e.g., writing prescriptions, dictating the discharge summary) while the patient is in the hospital after surgery for breast reconstruction or flap reconstruction procedures. Medicare has been denying the codes. Should we appeal these denials?

Answer:
No, don’t appeal the denials. Discharge care management is included in the 90-day post-operative global period for breast reconstruction and flap reconstruction procedures. The transitional care management codes have specific requirements, as noted in CPT resources, which are typically are performed by the patient’s primary care physician.

*This response is based on the best information available as of 05/12/16.

Incident-to Hospital Billing

May 12, 2016

Question:
If the physician practice is owned by the hospital, and the midlevel practitioners are employed by the hospital, can the physicians bill incident-to service and/or split shared visit in the hospital?
8 Things Your Medical Billing Service Should Be Doing

Physicians Practice – 2016
by Karen Zupko

What has your billing service done for you lately? A good vendor does more than just submit claims, send three patient statements, and hope for the best. Here are eight things you should expect a billing service to do, in
The effective use of physician assistants (PAs) and nurse practitioner (NPs) in an orthopaedic practice requires an understanding of key billing rules that apply to these nonphysician providers (NPPs). Compare your practice’s internal procedures to the following common questions and answers. The guidelines referenced are for Medicare claims; other payers may have different rules. The Medicare scenarios and guidelines described in this article apply the same way to both PAs and NPs.
**Tympanostomy Tube with Intratympanic Injection**

April 28, 2016

**Question:**
I did an intratympanic steroid injection and coded 69801 and 69433. Medicare paid 69801. Should I appeal the denial of 69433?

**Answer:**
No! CPT 69801 says Labyrinthotomy, with perfusion of vestibuloactive drug(s); transcanal. The CPT guidelines say: Do not report 69801 in conjunction with 69420, 69421, 69433, 69436 when performed on the same ear. By billing 69801 and 69433, for procedures on the same ear, you’ve unbundled the codes. The denial is accurate so you should not appeal. Furthermore, in the future, do not bill 69433 or 69436 (tympanostomy tube placement) or 69420 or 69421 (myringotomy) for the same ear when you also report 69801.

*This response is based on the best information available as of 04/28/16.*

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**Source for a Consult**

April 28, 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 04/28/16.

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**Excision of Scar**

April 28, 2016

**Question:**
Patient comes in for what they are calling scar revision and the note states that “standing cutaneous excess of the left abdominal scar” was sharply excised. We are billing with a diagnosis of hypertrophic scar (L91.0) and CPT codes of 11406 (excision of benign lesion) and 12034 (intermediate repair) for the procedure. On speaking with a co-worker regarding the note, since I’m new to plastics surgery, we are wondering if we should bill 15830 with 52 modifier because it appears to me that the excess skin is being removed. What do you think?

**Answer:**
CPT says for scar revision to use a complex repair code such
as 13100-13102. Do not use the benign lesion removal and intermediate repair code combination (11404 and 12034). Also, do not use 15830 – that code says Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy. CPT 15830 is meant for procedures commonly referred to as a panniculectomy to prevent the occurrence of recurring rashes, skin maceration, and yeast infections that develop in the abdominopelvic fold following extreme weight loss – not for scar revision.

*This response is based on the best information available as of 04/28/16.

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**Synovectomy Coding**

April 28, 2016

**Question:**
Since January we have not been able to get code 29875-59 paid. All of our claims are coming back bundled to code 29880. I have submitted the operative reports showing that it was a separate procedure, performed in a separate compartment however our appeals are also being denied. How do you recommend getting the claims processed correctly?

**Answer:**
Thanks for your inquiry. I think you are misinterpreting the intention of the (separate procedure) designation in the CPT code descriptor. In the surgery guidelines of CPT, the instructions state that codes designated as “separate procedure” should not be reported in addition to the code for the total procedure or service of which it is considered an integral component. A limited synovectomy would be considered an integral component of any arthroscopic procedure done on
the same knee. We would not recommend reporting these codes together if performed on the ipsilateral knee.

*This response is based on the best information available as of 04/28/16.

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**Coding Ultrasound – Guided Sclerotherapy**

April 28, 2016

**Question:**
I performed an ultrasound guided sclerotherapy. What ultrasound code should be used to reflect the guidance?

**Answer:**
Codes 36470 and 36471, Injection of sclerosing solution, may be reported with code 76942, Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation. Remember that ultrasound guidance procedures require permanently recorded images of the site to be localized, as well as a documented description of the localization process, either separately or within the report of the procedure for which the guidance is utilized.

*Source CPT Assistant May 2015.*

*This response is based on the best information available as of 04/28/16.*
Question:
One of our physicians treats patients using Sphenopalatine however; he is not preforming this as an injection but as a topical anesthetic. What procedure code should I use? I have found a 64505 code, is this correct? Please advise.

Answer:
According to CPT Advisors, it would not be appropriate to report code “64505, Injection, anesthetic agent; sphenopalatine ganglion”, as this code represents a procedure requiring the performance of an injection.

Performing the procedure with a topical anesthetic is not reported separately by any CPT code. This would be considered inclusive of an appropriate code. Alternatively, if performed in the absence of an accompanying E/M service, the unlisted code 30999, nose, or 64999, unlisted procedure, nervous system, should be reported.

*This response is based on the best information available as of 04/28/16.*