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?

Answer:
Click here for the video answer.

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

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.
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.*
**Coding Sphenopalatine**

April 28, 2016

**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.*

**New vs. Established Patient**

April 14, 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 scrutiny.

*This response is based on the best information available as of 04/14/16.

Billing Bilateral Procedures

April 14, 2016

Question:
I was hoping you could answer a quick coding question for me. For example, in bilateral coding a breast reduction (19318) or a TRAM flap (19367), do I put the codes on one line or 2? Example: 19318-50 or 19318 and 19318-50.

Answer:
The charge entry format depends on the payer preference. Medicare prefers 19318-50 (one line, 1 unit, double your single fee) while some other payors want 19318 (one line, 1
unit, your single fee) and 19318-50 (second line, 1 unit, your single fee). It’s best to contact the payor to determine their preference. First check on-line in their provider billing manual – usually the preferred format is described there. Attend one of our plastic surgery coding courses by clicking here. Hope to see you there!

*This response is based on the best information available as of 04/14/16.

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**Code 37202 – Deleted!**

April 14, 2016

**Question:**
What happened to code 37202 for non-thrombolytic infusions?

**Answer:**
The code for transcatheter therapy, infusion other than thrombolysis; any type (37202) has been deleted, along with its paired radiological supervision and interpretation code for guidance (75896). Peripheral injection of a non-thrombolytic drug, verapamil for example, is considered inclusive to the primary procedure. A replacement code for 37202 was developed but it now applies only to intracranial infusions.

*This response is based on the best information available as of 04/14/16.