Aneurysm in a bypass graft? How is this coded?

April 27, 2017

Question:
The surgeon repaired an aneurysm in a lower extremity bypass graft through an open approach. Is this coded with an aneurysm code?

Answer:
Open repair of an aneurysm that occurs in a lower extremity bypass graft is coded as a bypass graft revision, using the appropriate open revision code (35876-35884).

*This response is based on the best information available as of 04/27/17.

Corpectomy Denial

April 27, 2017

Question:
We submitted an op note at the request of a payer (not Medicare) and they denied the corpectomy code we billed, 63081 with the fusion code, saying the documentation doesn’t support it. Instead, they paid us for 22551. I don’t understand this because my neurosurgeon’s operative note says he did a corpectomy.

Answer:
Ah, but does the operative note specifically state he removed at least 50% of the cervical vertebral body – or that he did a total corpectomy – to justify using a corpectomy code. I suspect not which is why the payer “downcoded” 63081 and the fusion code to the anterior cervical decompression/discectomy and fusion code, 22551.

CPT guidelines specifically state that at least 50% of the cervical vertebral body must be removed to support using a corpectomy code. Recently, Cigna released guidance that says: “A targeted subset of cervical vertebral corpectomy claims billed with CPT codes 63081 and 63082, and where abuse is probable, will be pended. The operative report will then be reviewed before reimbursement to determine if the corpectomy criterion is met. If it is not met, the claim will be denied.”

The point is that the percentage of the vertebral body removed must be documented in the operative note to justify reporting a corpectomy code.

*This response is based on the best information available as of 04/27/17.

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**Scribe Question**

April 27, 2017

**Question:**
In my office, we use a PA as a scribe for new patient office visits for our doctors. We have an electronic medical record and the scribe signs in under her own name when she begins notating for the doctor. What is the correct way to notate in
the medical record that the PA is only acting as a scribe and not performing the service personally?

Answer:
Good question. In order to clearly indicate what was performed, the documentation must identify who rendered the service and that the PA was acting solely as a scribe and did not perform any of the services. Remember, a scribe does not ask the patient questions or perform any examination of the patient. Both parties need to sign the medical record (electronically will suffice) and attest to the situation. Noridian, the Jurisdiction E local Medicare contractor, gives the following acceptable attestation example:

“I, ____________, am scribing for, and in the presence of, Dr. ___________.” for the scribe; and “I, Dr. __________, personally performed the services described in this documentation, as scribed by ____________ in my presence, and it is both accurate and complete.” for the physician.

Some payors only require the physician to sign the note as an attestation and not make a separate statement (as in the Noridian example above). You may want to check with your payors to see if they have specific verbiage that they look for to support the use of a scribe.

*This response is based on the best information available as of 04/27/17.
**Assistant Surgeon Payments**

April 27, 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 04/27/17.*

**Billing for Pre-Op H&P Visit**

April 27, 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.
Nail Biopsy

April 27, 2017

Question:
When performing a nail biopsy do we use CPT 11100?

Answer:
For a nail biopsy the correct CPT code is 11755-Biopsy of nail unit (e.g., plate, bed, matrix, hyponychium, proximal and lateral nail folds). You would not report 11100 as this is a biopsy of the skin.

Hip Injection with Fluoroscopy

April 27, 2017

Question:
A physician in our group is taking the patient to the surgery
center for a hip injection using fluoroscopy. We know CPT code 20611 includes ultrasound guidance but is fluoroscopy also considered inclusive? I am looking at CPT code 77002.

Answer:
Thanks for your inquiry. Your question is appreciated. In reviewing the 2017 CPT Manual, we notice a revision to this code and a guideline parenthetical was added to CPT code 77002. The code was revised from a stand-alone CPT code to an add-on code. The guideline parenthetical lists primary surgical CPT codes where CPT code 77002 may be reported in addition to the procedure. CPT code 20610 (major joint injection) is included in this list.

Assuming all documentation supports the hip injection with fluoroscopic guidance the following services are submitted:

20610

77002-26 (the physician must add the modifier 26 as the procedure is performed in a facility location)

Assign anatomic modifiers according to payor policy.

*This response is based on the best information available as of 04/27/17.

Billing “Incident to”

April 27, 2017

Question:
Whose NPI number do we bill under when a PA sees the patient in the office under the “incident to” rules for Medicare? We bill under the NPI number of the physician who wrote the original treatment plan for the patient. Is that correct?

Answer:
No, when billing “Incident to,” bill under the NPI number of the physician in the office who is supervising. The guidelines are very clear that a physician must be present in the “office suite”. The PA’s visit must be billed under the physician who is in the “office suite” at the time the PA is managing the care of the patient which may not necessarily be the physician who documented the original treatment plan.

*This response is based on the best information available as of 04/27/17.

Registered Nurse FA (First Assistant) vs. a Formal Mid-Level Provider (PA, etc.) Billing Difference

April 13, 2017

Question:
Is there a difference in billing and especially reimbursement for a registered nurse FA (first assistant) vs. a formal mid-level provider (PA, etc.)?

Answer:
Yes, there is a difference in how these two types of practitioners can be billed and expected reimbursement. The answer will be payor dependent.

**Physician Assistants, Nurse Practitioners and Clinical Nurse Specialists**

Medicare credentials only Physician Assistants (PA), Nurse Practitioners (NP), and Clinical Nurse Specialists (CNS) as assistants at surgery for the purpose of orthopaedic surgery. Assistant claims are reported in the PA, NP or CNS name with the AS appended. Medicare, when payment is allowed, reimburses the practice at 13.6% of the surgeon’s allowable for the primary procedure. The appropriate multiple procedure payment formula is applied to the subsequent procedures on the same day.

Other payors may or may not follow Medicare rules. Reimbursement and claim submission are based on contractual arrangements. Check individual payor rules for claim submission rules (e.g. modifier use, separate claim) and expected reimbursement.

**RNFAs**

RNFAs are not credentialed by Medicare, so you would not bill or expected to be paid for their work by the MAC.

Other payor rules for RNFA coverage/reimbursement will vary, and would need to be researched directly with the health plans in your market.

*This response is based on the best information available as of 04/13/17.*
**Venous Stenting: What’s the Proper Code?**

April 13, 2017

**Question:**
What code is reported for a venous angioplasty and stenting in the lower extremity? For example, the left external iliac vein? Would 37221 be appropriate?

**Answer:**
No, 37221 is specifically for arterial angioplasty and stenting and would not be appropriate for venous angioplasty and stenting. Use code 37238, transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, initial vein. Catheterization and diagnostic imaging may be separately reported with 37238.

*This response is based on the best information available as of 04/13/17.*