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.

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

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**Scribe Question**

August 10, 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 08/10/17.

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**Paramedian Forehead Flap on Previous Mohs Surgery**

July 27, 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 07/27/17.*

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**Assistant Surgeon Payments**

July 13, 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.
**Report actinic keratosis and seborrheic keratosis with 17000-17004 codes?**

June 22, 2017

**Question:**
If a patient presents to the office with both AKs and SKs. The doctor destroys 11 AKs and 5 SKs. Are these all reported with 17000-17004 codes?

**Answer:**
No. The actinic keratosis (AKs) are considered premalignant and are reported using codes 17000-17004. The seborrheic keratosis (SKs) are considered benign and are reported using codes 17110-17111. In your case, the following codes should be reported:

- 17110 Destruction of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions
- 17000-59 Destruction premalignant lesions; first lesion
- 17003 X 10 Destruction premalignant lesions; second through 14 lesions, each

Make sure that you pay attention to the quantities in the code
descriptors so that the proper units are billed. There is a CCI edit between 17110 and 17000 so modifier 59 (or XS) would need to be appended to 17000 to ensure proper adjudication. Hope this helps.

*This response is based on the best information available as of 06/22/17.

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**Adjacent Tissue Transfer**

June 8, 2017

**Question:**
If I undermine the ear to close a keloid defect of can I use the adjacent tissue transfer code 14060?

**Answer:**
The CPT guidelines for adjacent tissue transfer states: “Undermining alone of adjacent tissue to achieve closure, without additional incision does not constitute adjacent tissue transfer, see complex repair codes 13100-13160”. If an additional incision is not performed you would report a complex repair code.

*This response is based on the best information available as of 06/08/17.*

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Biopsy and Injection Coding

May 25, 2017

Question:
If my physician reports a biopsy on the same date as an intralesional injection (different sites) can I report both codes? Should I use Modifier 59?

Answer:
You can report a biopsy (11100) for the first lesion and 11101 for each additional lesion biopsied. You may also report an intralesional injection (11900) on the same date of service if performed on a different lesion.

Modifier 59 should not be reported as it is not bundled under the National Correct Coding Initiative (NCCI). You should only use Modifier 59 if the two codes are bundled under NCCI and both procedures are distinct and separate. In this case since the two codes are not bundled, you should append Modifier 51 (multiple procedures) to CPT 11900 if your payor accepts the use of this modifier. Since 11900 has a lower RVU, Modifier 51 supports this as a secondary procedure. Expect payment to be reduced by 50% for the second procedure.

*This response is based on the best information available as of 05/25/17.

Shave Technique

May 11, 2017
**Question:**
My physician documents a biopsy via “shave technique”. Is this the correct way to document a biopsy and report the procedure with 11100?

**Answer:**
Payors discourage physicians from documenting in the record a “shave biopsy” or “shave technique” which is many times confused with a shave excision. When reporting and documenting a biopsy it is important to document the site of the biopsy and avoid the term “shave”.

CPT 11100 is reported for the first biopsy and 11101 is reported for each additional lesion biopsied.

When the term shave biopsy or shave technique is documented is should be reported as a shave excision using CPT category 11300-11313. Code selection is dependent on the location (site) and size of the lesion shaved.

*This response is based on the best information available as of 05/11/17.*

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**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.

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

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**Nail Trimming or Clippings**

April 13, 2017

**Question:**
We perform a great deal of nail clippings for patients with fungus in our office. At present we have not been charging for this. Is there a CPT code for this service?

**Answer:**
For nail trimming or clippings, the CPT code is 11719 – Trimming of nondystrophic nails, any number. However most insurance companies don’t reimburse for this CPT code. However, if you are evaluating the patient or seeing the patient in follow up, you might want to bill an evaluation and management service instead of 11719.

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