Telehealth Billing

April 19, 2018

Question:
We want to offer telehealth in our office as an added service line to our patients. How do we indicate to the insurance company that the visit was a telehealth visit?

Answer:
There are a few ways that your claim form will tell a payor that the visit was performed remotely. A new Place of Service code was added to denote a telehealth visit – 02. Using this place of service instead of 11 for office will let the payor know that the visit was done via telehealth. Commercial payors may also require modifier 95, GT, or GQ to denote a telehealth service. Modifier 95 is a CPT modifier that states that the service was done via live, interactive video. Modifier GT is a HCPCS II modifier that states the same thing, but was used first until modifier 95 was added. Modifier GQ is a HCPCS II modifier that states the visit was done using store and forward technology (not live). Check with your carriers to see which modifier they require. For Medicare, only modifier GQ is required when used appropriately for Alaska and Hawaii. Otherwise, Medicare uses the place of service to indicate the visit was via telehealth. With those two pieces of information for commercial payors (place of service and modifier), they will know that the visit was a telehealth visit.

*This response is based on the best information available as of 04/19/18.*
Incident-to Billing

March 29, 2018

Question:
We have added a PA to the practice and want to make sure we are using him to the fullest capacity. We were told that he can see Medicare patients and we can bill it under our physician and get paid at the full fee schedule rate. Is this true?

Answer:
It depends. Medicare has Incident-to guidelines that allow NPPs to see patients and bill under the physician’s NPI number and get paid at the full fee schedule rate. According to the guidelines, in order to bill a visit under the Incident-to guidelines, the physician would have to have seen the patient first and developed a treatment plan that the NPP is following. The physician also has to be in the office suite (not doing rounds at the hospital) when the patient is being seen. Finally, the documentation has to show that there is continued involvement of the physician in the patient’s care. If those criteria are met, the visit may be billed as Incident-to the physician and be paid at the full fee schedule. So, an NPP cannot see new patients or established patients with new problems and bill them as incident-to visits, but can bill them under their own NPI number and be paid at the 85% rate. KZA recommends that the physician countersign the notes when an NPP sees a patient as incident-to. That will prove they were in the office suite and that they have continued involvement in the patient’s care.

*This response is based on the best information available as of 03/29/18.*
Modifier 25 Use

March 15, 2018

Question:
If a patient is coming in for destruction of AKs, can my doctor bill for an E/M too? He has to evaluate the sites before doing the destruction.

Answer:
If a patient is scheduled for the minor procedure, then the decision to perform it has already been made. When the patient presents for the procedure, it is common medical practice for the area(s) to be assessed and to have a discussion with the patient regarding them before performing the procedure. In every surgical CPT code, there is an E/M service paid in the global package. In order to bill an E/M separately with modifier 25, the documentation needs to support that the E/M service went over and above what is normally done for that minor procedure. In your case, since the decision has been made, and the patient has no other complaints, only the minor procedure should be billed.

*This response is based on the best information available as of 03/15/18.*
Multiple Lesion Excisions. Do you add them together?

March 1, 2018

**Question:**
If I am excising multiple basal cell carcinomas on a patient’s chest, do I add the sizes and margins together and report one code since they are in the same anatomic group of CPT codes?

**Answer:**
No. For lesion excisions, each lesion plus its most narrow margin are reported separately. CPT guidelines state to “report separately each malignant lesion excised.” Remember, simple closure is bundled into lesion excision, but you would separately report intermediate or complex repairs. And, depending on the type of repairs performed, you may need to add the repairs together.

*This response is based on the best information available as of 03/01/18.*

Repairs with Mohs Surgery

February 15, 2018

**Question:**
I know that simple repairs are included with lesion excisions, but what about Mohs surgery?

**Answer:**
Although simple repairs are included (bundled) into almost all integumentary codes, no repair is bundled into Mohs per the NCCI and CPT. The CPT guidelines for Mohs state that if a repair is performed, you can use separate repair, flap or graft codes to report. You can report simple repairs (12001-12018) along with Mohs codes (17311-17315).

*This response is based on the best information available as of 02/15/18.

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How to code for shave biopsy?

February 1, 2018

**Question:**
One of the dermatologists in the office documents that he performs shave biopsies of lesions. Those should just be coded as biopsies, right? Not shaves?

**Answer:**
That is a great question. By CPT definition, there is no such thing as a shave biopsy. There are codes for shaving of lesions (11300-11313) and there are codes for biopsies of lesions (11100, 11101), but there are no codes for shave biopsies of lesions. He needs to document clearly whether it is a shave or biopsy that he is performing. Show the two separate sections of CPT for these procedures to him. This is an area for clinical documentation improvement. Some of the shave removal codes are lower valued (less reimbursement) than a biopsy. If a payor were to review the record with the confusing verbiage, they may reimburse for the lesser valued procedure.
Mohs Surgery without a Confirmed Pathology Report

January 4, 2018

**Question:**
Can I bill Mohs surgery without a confirmed pathology report?

**Answer:**
No, A biopsy must be performed on the skin lesion for which Mohs’ surgery is planned in order for the physician to determine the exact nature of the lesion(s) to be removed. If a biopsy has not been performed within 60 days, the Mohs surgeon can perform the biopsy on the same date as the Mohs surgery by appending Modifier 59 to the biopsy as it is bundled with Mohs surgery under the National Correct Coding Initiative (NCCI). However the biopsy cannot be performed at the same time as Mohs surgery. The surgeon must have the biopsy results prior to surgery.

*This response is based on the best information available as of 01/04/18.*
Report 97597 for ulcer debridement down to the subcutaneous tissue?

November 16, 2017

Question:
When performing ulcer debridement down to the subcutaneous tissue do we report the service with CPT 97597?

Answer:
No, CPT 97597 and 97598 are reported for debridement of the epidermis and/or dermis. For ulcer debridement of the subcutaneous tissue you would report 11042 for the first 20 sq cm and CPT 11045 for each additional 20 sq cm. Make certain documentation contains the sq cm of the debridement. These codes are used when there is no direct closure of the wound at the time of debridement nor is there a plan for closure as the wound will heal by secondary intention.

*This response is based on the best information available as of 11/16/17.

Simple Laceration Repair on Skin Right Upper Eyelid

November 2, 2017

Question:
My physician did a simple laceration repair on the skin right upper eyelid. What procedure code should I report? My physician wants to use 67930.

Answer:
For a simple repair of the skin of the eyelid, you should report 12011-12018 based on cm size of the repair. Report 12011 for a total length of 2.5 cm or less; 12013 for 2.6 cm to 5 cm; 12014 for 5.1 cm to 7.5 cm; 12015 for 7.6 cm to 12.5 cm; 12016 for 12.6 cm to 20 cm; 12017 for 20.1 cm to 30 cm; and 12018 if the total length is greater than 30 cm. When reporting repair of wounds, the lengths of all repairs are added together and the total is listed for each anatomical site. If the repair involves the lid margin you should report the repair with CPT 67930 (Suture of recent wound, eyelid, involving lid margin, tarsus, and/or palpebral conjunctiva direct closure; partial thickness) or 67935 (full thickness).

*This response is based on the best information available as of 11/02/17.

Moderate sedation Denials. How do we get paid for 99153?

October 19, 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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<tbody>
<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>
<tr>
<td>G0500</td>
<td><strong>G0500</strong> 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. <em>Use only for GI endoscopy procedures for Medicare patients.</em></td>
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</tbody>
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*This response is based on the best information available as of 10/19/17.*