Assistant Surgeon Payments

August 10, 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 08/10/17.

Closure After Moh’s Surgery

July 27, 2017

Question:
I did the closure for a patient’s left ear defect after the Moh’s surgeon excised the basal cell carcinoma at the same operative session. I had to remove a little devitalized tissue before closing the wound with a full thickness graft. Can I code both 15260 (full thickness graft) and 11043 (wound debridement)?
Answer:
No. The 1104x codes are for debriding an open wound that will heal by secondary intention such as a chronic venous stasis ulcer. You’ll use only 15260 for your reconstructive procedure.

*This response is based on the best information available as of 07/27/17.

Billing for Pre-Op H&P Visit

July 13, 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 07/13/17.

STAY UPDATED WITH KALERTS
Facial Nerve Monitoring with Ear Procedures

June 22, 2017

Question:
Can I bill for facial nerve monitoring during a cochlear implant or mastoidectomy procedures?

Answer:
Facial nerve, and any cranial nerve, monitoring is included in the primary procedure code (e.g., cochlear implant, mastoidectomy) for the surgeon and should not be separately reported according to both CPT and Medicare. A completely different provider, other than the surgeon or assistant surgeon or co-surgeon or anesthesiologist, may provide and bill for the monitoring.

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

Tympanoplasty with Middle Ear Exploration

June 8, 2017

Question:
I billed 69631-RT for the transcanal tympanoplasty, 20926-RT for the temporalis fascia harvest, and 69440-RT for the middle ear exploration. Should I have used modifier 59 on 69440
because it didn’t get paid?

Answer:
No! You should not have coded 69440 for exploring the same ear on which you did the tympanoplasty. Exploring the middle ear is inherent in 69631 and all tympanoplasty as well as mastoidectomy codes and should not be separately reported with 69440.

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

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Total Thyroidectomy and Reimplantation of Parathyroids

May 25, 2017

Question:
My doctor did a total thyroidectomy and reimplanted one of the parathyroid glands into the sternocleidomastoid muscle. Can I code 60512 in addition to 60240?

Answer:
CPT 60240 for the total thyroidectomy is correct. However, if one or more of the parathyroid glands is reimplanted in the same surgical exposure (e.g., SCM muscle) then it is not accurate to separately code +60512. The reimplantation should be done through a separate surgical approach/incision for +60512.
Billing Medicare Patient Admittance

May 11, 2017

Question:
If a Medicare patient has been admitted to the hospital as an inpatient and the patient is transferred to my care in the ED before they are moved to an inpatient bed, do I bill an ED visit or an initial hospital care code when surgery is not planned?

Answer:
Since the patient has been formally admitted you would report CPT codes 99221-99223 for initial hospital care depending the documentation and medical necessity for the complexity of the patient. Keep in mind Medicare does not pay for inpatient or outpatient consultations.

*This response is based on the best information available as of 05/11/17.
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.*
**Billing “Incident to”**

April 13, 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 is assigned to the PA. 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 the 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 not the physician the PA is assigned.

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

March 30, 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 03/30/17.*