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

November 30, 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; 99153 (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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<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>x99151</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>
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<tr>
<td>x99152</td>
<td>initial 15 minutes of intra-service time, patient age 5 years or older</td>
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<tr>
<td>Ņ99153</td>
<td>each additional 15 minutes intra-service time (List separately in addition to code for primary service)</td>
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<tr>
<td>G0500</td>
<td>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 Use only for GI endoscopy procedures for Medicare patients</td>
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*This response is based on the best information available as of 11/30/17.*
Dizziness and E/M Code Level

November 16, 2017

Question:
When I see an adult new patient with a chief complaint of dizziness, I can automatically code a level 4, 99204, right?

Answer:
Oh, only if E/M coding were that easy! Don’t forget, for 99204 you must have medical necessity for and perform a comprehensive History and a comprehensive Exam (8 organ systems for the 1995 guidelines, meet the assessment “bullets” which include a laryngeal mirror exam for the 1997 guidelines). Lastly, the medical decision making must be of moderate complexity. Meeting all 3 of these requirements is mandatory for 99204 and may not be easily met when the chief complaint is dizziness. There is potential for the counseling time requirement of 45 minutes of face-to-face time, with greater than 50% of it being spent counseling, to be met to support 99204. Be sure to appropriately document this and your specific discussion points if choosing the code based solely on time counseling on the dizziness.

*This response is based on the best information available as of 11/16/17.*
Question:
Can I bill 31525 (31526) for a diagnostic laryngoscopy performed at the same operative session as the laryngectomy (31360)? I do this map out the tumor for the laryngectomy and make sure there are no secondary tumors that may have occurred since I scoped the patient previously.

Answer:
A diagnostic endoscopy is included in a definitive therapeutic surgical procedure code when performed on the same anatomic structure at the same operative session in the situation you describe. Therefore, it should not be separately reported.

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

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Question:
Can I bill 43191 for the rigid esophagoscopy (or 43200 for a flexible esophagoscopy) performed at the same operative session as the glossectomy (eg, 41150)? I do this to map out the tumor for removal and make sure there are no other tumors that may have occurred since I saw the patient a week before.
Answer:
No. A “scout” or “mapping” diagnostic endoscopy is included in the definitive procedure performed on the same anatomic structure at the same operative session in the situation you describe.

*This response is based on the best information available as of 10/19/17.

Abdominal Fat Graft

October 5, 2017

Question:
I billed 15770 (Graft; derma-fat-fascia) for an abdominal fat graft. After reviewing my operative report, the insurance company denied the code saying it was wrong. What code should I use?

Answer:
CPT 15770 is a composite graft meaning more all layers – dermis, fat and fascia – are used to repair a defect. In your situation, you used only one layer – fat. Therefore, the correct code is 20926, Tissue grafts, other (eg, paratenon, fat, dermis).

*This response is based on the best information available as of 10/05/17.
Endoscopic Sphenopalatine Artery Ligation

September 21, 2017

Question:
I did an endoscopic ligation of the left sphenopalatine artery for recurrent epistaxis in a patient with Coumadin-induced coagulopathy. I don’t see a CPT code for this procedure—can I use 30920?

Answer:
No, you’ll need to use an unlisted code such as 30999. Your comparison code can be 30920 (Ligation arteries; internal maxillary artery, tranantral). However, using 30920 is not accurate as this code requires a transantral approach (which you didn’t do) and it requires ligation of the internal maxillary artery (which wasn’t done). That said, be on the lookout in 2018 as there may likely be a new CPT code for this procedure. Kim Pollock will be doing a webinar with the 2018 coding updates for ENT as it appears there will be several!

*This response is based on the best information available as of 09/21/17.*
Post-Op hemorrhage repair. Is it billable?

September 7, 2017

**Question:**
Can I bill for taking the patient back to the OR to explore and repair post-op hemorrhage on day post-op? I heard that all complications are included in the payment of the original surgery.

**Answer:**
Yes, you may bill for this. CPT and Medicare agree that taking the patient back to the OR to treat a complication is billable. A modifier 78, unplanned return to the OR) is appended to the procedures performed to treat the hemorrhage. The appropriate ICD-10 code for a postoperative hemorrhage would also be reported.

*This response is based on the best information available as of 09/07/17.*

Global Period for Surgery. Is it billable?

August 24, 2017

**Question:**
My patient presented to the ED with an infection at the incision site from a surgery that I did 4 weeks ago. It has a
90 day global. I was on vacation so my general surgeon partner saw the patient and admitted her. What should she bill for this?

**Answer:**
Since the patient is in a global period for the surgery, this is not billable, by you or any of your partners of the same specialty.

From a billing perspective, you and your partners are a single billing entity. Therefore, you all share the global package of the patient’s surgery.

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

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**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.
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.*