New Patient Visit and Modifier 57

September 29, 2016

Question:
If I see a new patient and during that visit I identify the need for surgery the same day, can I append a Modifier 57 to the E/M service and get paid?

Answer:
You determine during the evaluation that the patient would need surgery the same or next day for a major procedure (90 day global), append Modifier 57 to the E/M service. If the procedure is a minor procedure with at 10 day global and the E/M service is significantly separately identifiable, then report the E/M service with Modifier 25.

Use caution when appending the 25 Modifier as CMS has indicated that there is an inherent E/M service in every procedure and routine use of Modifier 25 may create payer scrutiny.

*This response is based on the best information available as of 09/29/16.

Capsulectomy and Revision of
Breast Reconstruction

September 29, 2016

Question:
My doctor did a partial capsulectomy to revise the inframammary fold as well as fat grafting to some defects on a reconstructed breast. Additionally, he revised the scar and took off some excess lateral breast tissue. We submitted the following codes: 19380, 19371-59, 20926-59, and 15839-59. We only got paid on 19380. I have appealed the denial twice but no luck. Can you please help?

Answer:
Sorry – can’t help! Actually, all the procedures you performed are covered in one code, 19380 (Revision of reconstructed breast).

*This response is based on the best information available as of 09/29/16.

AV Access Procedures

September 29, 2016

Question:
I am continually confused by the AV access codes, in particular, the percutaneous codes. I have one specific question. Does code 36147 include all imaging, venous and arterial?

Answer:
Yes, the entire range of venous access codes are very confusing and complex! Code 36147 is an all-inclusive code and includes all venous imaging from the venous side of the access to and including the right atrium. In terms of arterial, 36147 includes the area of the arterial anastomosis, what CPT describes as the peri-anastomotic site. If it is clinical necessary (and documented as such) to image areas distal from the arterial anastomosis; the entire extremity for example, an extremity arteriogram may be reported.

It’s important to note that these codes may be revised in 2017. Watch for a KZA webinar in November/December of 2016, “2017 Update in Vascular Coding”.

Please join us in Chicago on October 21-22, 2016 for the SVS sponsored Vascular Coding course with KZA consultant Teri Romano as a faculty member. Can’t make the October course or have too large a staff for all to attend? Contact KZA for an intensive and interactive vascular coding course at your location.

*This response is based on the best information available as of 09/29/16.*

**New Patient Admission Charge**

September 29, 2016

**Question:**
I took the General Surgery coding courses you taught in New York at The Cornell Club and believe you have already made a difference in how I code. I have a question. After I see a
patient in the office and schedule an elective surgery, I prepare an H&P for this patient to be added to their chart upon admission for the planned elective surgery. A New Patient charge is generated at the office visit. Should there be an additional “new patient admission” charge generated at the time of their admission for the elective surgery, or is that considered part of the New Patient charge at the time of the office visit when the elective surgery was scheduled?

**Answer:**
Thank you for attending the American College of Surgeons coding course. I am very glad you found it helpful in your coding efforts. To answer your question, the patient visit at the time of the admission for elective surgery is part of the global package and not separately reported.

*This response is based on the best information available as of 09/29/16.*

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### Global Period Modifiers: How Do They Impact Reimbursement?

**September 29, 2016**

**Question:**
What reimbursement should we expect when using the global period modifiers 58, 79 and 78?

**Answer:**
Global period modifiers are used to indicate that a subsequent procedure was performed during the global period of a prior
procedure. Modifiers alert the payer of your rationale for allowing payment for the subsequent procedure. The modifiers and reimbursement impact of each is shown below:

Modifier 58: Indicates that a subsequent procedure was performed as a (1) planned or anticipated (staged); (2) more extensive than the original procedure; or (3) for therapy following a surgical procedure. Reimbursement should be 100% of the allowable and the global period is extended to that of the subsequent procedure.

Modifier 79: Is appended to CPT code to show that an unrelated procedure was performed during the global period of a prior procedure. Again, reimbursement should be at 100% of the allowable and you’re now in a separate global period that is related to the subsequent procedure.

Modifiers 78: Indicates that an unplanned, related procedure was performed in the operating room, catheterization or endoscopy suite. Typically this is treatment of a complication such as wound dehiscence, infection, etc. Reimbursement is typically at 70-80% of the allowable. Why? The reduction accounts for overlapping pre- and post-op care which was paid under the original procedure. Therefore, the payment for modifier 78 is for only the intra-operative portion of the unplanned, related procedure.

*This response is based on the best information available as of 09/29/16.
Reimbursement: Co-Surgery

September 29, 2016

Question:
What is the reimbursement for co-surgery using modifier 62? Is it different for the primary and co-surgeon?

Answer:
For Medicare, co-surgery requires two different specialties performing separate parts of a single CPT code. For both surgeons, modifier 62 is appended to the appropriate CPT code(s). Medicare multiplies the allowable by 125% and splits the reimbursement exactly in half, resulting in a payment of 62.5% to each surgeon. For example, when neurosurgery and otolaryngology perform an endoscopic transnasal pituitary tumor removal each surgeon reports 62165-62 as the primary procedure code. Both surgeons would receive 62.5% of Medicare’s allowable. So to answer your question, the payment is the same for both surgeons. Both surgeons dictate an operative note describing their work and both have post-operative responsibilities.

*This response is based on the best information available as of 09/29/16.*
**Surgeon**

September 29, 2016

**Question:**
What is the reimbursement for an assistant surgeon using modifier 80? Is the payment different for the primary and the assistant? What about a PA or nurse practitioner who assists at surgery?

**Answer:**

An assistant surgeon is described as one surgeon, of the same or a different specialty, providing assistance during a surgical procedure or CPT code.

Modifier 80 (modifier 82 for an assistant surgeon in an academic setting when a qualified resident is not available) is appended to any CPT code the assistant participates in. Medicare reimburses 16% of the allowable for the assistant surgeon (modifier 80 or 82) and multiple procedure/bilateral procedure reductions also apply. The primary surgeon’s reimbursement is not affected. In an assistant surgeon scenario, the assistant need not and should not dictate a separate note. However, it is critical that the primary surgeon document in his/her note, specifically what the assistant did. Stating an assistant was needed because the case was complex is not sufficient. The primary surgeon must state what the assistant did, for example, assisting with positioning and retraction, surgical closure, etc. When a physician assistant or nurse practitioner assists in surgery, Medicare reduces their reimbursement by 15% of what a physician would be paid for assisting, and Medicare directs us to designate a PA or NP service using modifier AS (instead of modifier 80).

Keep in mind, Medicare does not allow payment for assistant support for all surgical CPT codes. For private payers, coding
Reimbursement: Co-Surgery

September 15, 2016

Question:
What is the reimbursement for co-surgery using modifier 62? Is it different for the primary and co-surgeon?

Answer:
For Medicare, co-surgery requires two different specialties performing separate parts of a single CPT code. For both surgeons, modifier 62 is appended to the appropriate CPT code(s). Medicare multiplies the allowable by 125% and splits the reimbursement exactly in half, resulting in a payment of 62.5% to each surgeon. For example, when neurosurgery and otolaryngology perform an endoscopic transnasal pituitary tumor removal each surgeon reports 62165-62 as the primary procedure code. Both surgeons would receive 62.5% of Medicare’s allowable. So to answer your question, the payment is the same for both surgeons. Both surgeons dictate an operative note describing their work and both have post-operative responsibilities. For private payers, coding guidelines and payment may vary.

*This response is based on the best information available as of 09/15/16.*
Diagnosis Code for Laryngopharyngeal Reflux

September 15, 2016

Question:
I’m getting used to ICD-10-CM! Thanks so much for teaching me about it. I do have a question though. I can’t seem to find a diagnosis code for laryngopharyngeal reflux. What do you suggest?

Answer:
Actually, we’ve always suggested using K21.9, Gastroesophageal reflux disease without esophagitis. Coincidentally, in a recent issue (first quarter 2016) of the American Hospital Association’s The Coding Clinic, the same advice was provided.

*This response is based on the best information available as of 09/15/16.

Signing NPP Notes

September 15, 2016
Question: Do I have to sign each of my NP’s notes that are reported incident to?

Answer: The guidelines for reviewing and signing NPP documentation are set by each state in its scope of practice regulations. Each practice must research those requirements individually. But as an employer, you are responsible for the care provided by the NP, and reviewing and signing off on the notes may be an efficient method for keeping tabs on patient treatment.

*This response is based on the best information available as of 09/15/16.