Global Period for Surgery. Is it billable?

October 5, 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.

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

Billing “Incident-to”

October 5, 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 10/05/17.

Thrombectomy in the Dialysis Circuit

October 5, 2017

Question:
If thrombectomy is performed once in the peripheral segment and once in the central segment of the dialysis circuit, can code 36904 be reported twice?

Answer:
Code 36904 is reported once, no matter how many times thrombectomy is performed in the peripheral and/or central segment.

*This response is based on the best information available as
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.

Billing for Pre-Op H&P Visit

October 5, 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.

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What’s causing the revenue loss in endoscopy center?

Abdominal Fat Graft

October 5, 2017

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

Billing  Medicare  Patient Admittance

September 21, 2017

Question:
I was consulted to see a Medicare patient in the emergency room (ER) by the Emergency Department physician. When I arrived, the patient was still in the ER but had been admitted to the hospitalist and was waiting for a bed.

Answer:
Since the patient is Medicare and has been formally admitted you would report CPT codes 99221-99223 for this consultation service, even though the patient is physically in the ED. Keep in mind Medicare does not pay for inpatient or outpatient consultations.

*This response is based on the best information available as of 09/21/17.
Sentinel Node Mapping in Mastectomies

September 21, 2017

Question:
Sentinel node mapping was performed and documented in both axilllas. Is code +38900 reported once or twice?

Answer:
Sentinel node mapping may be reported bilaterally with a 50 modifier. Claim form reporting in a single line format (38900-50) or on two lines (38900, and 38900-50) will be dependent on the payor.

*This response is based on the best information available as of 09/21/17.

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, transantral). 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.*