Sentinel Node Mapping in Mastectomies

September 21, 2017

Question:
Sentinel node mapping was performed and documented in both axillas. 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.

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**Scribe Question**

September 21, 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
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
“II, 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 09/21/17.*

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

September 21, 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:**
The answer depends on your place of service! 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, 99151 and 99152 have work and total RVU’s assigned. Code 99153, for the second 15 minutes, (or a minimum of 23 minutes total of sedation) does not have professional work RVU value assigned; thus in a Facility setting Medicare will not pay, as there is no physician work and Incident-To does not apply in a Facility setting. In a private practice (Non Facility) Medicare will pay for these additional minutes performed by the physician employed staff as Incident-To services are met assuming the physician continues to provide direct supervision. To recap: In a Facility Setting, Medicare considers all physician work for moderate sedation to be covered by CPT codes 99151 and 99152. In a Non Facility setting, Medicare will reimburse the private practice assuming Incident-To rules are met.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
<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>
</tbody>
</table>
Coding Debridement for an Ulcer

September 21, 2017

Question:
I debrided and ulcer. How do I know if I use 97965 or 11042?

Answer:
Code 97597 is described by CPT as a debridement (e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (e.g., fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less. By definition it is exclusively for selective debridement of the skin, epidermis and dermis.

In contrast, code 11042, is for a deeper selective debridement, one that includes the dermis, epidermis and subcutaneous tissue. The code description states Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less.
For any debridement make sure to document the depth of the tissue debrided, the location of the debridement and the size of the debridement. Other selective debridement codes (11043 and 11044) are also coded by the depth of tissue removed; muscle and/or fascia for 11043 and bone for 11044.

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

Coding Pulsed Radiofrequency

September 21, 2017

**Question:**
How is pulsed radiofrequency coded?

**Answer:**
Pulsed radiofrequency stuns the nerve but does not destroy it. Therefore, the existing radiofrequency codes are not appropriate for pulsed radiofrequency. An unlisted code is reported.

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

September 21, 2017

Question:
I billed 30465 for an injection of a bioabsorbable implant into the lateral nasal wall to repair nasal vestibular stenosis. The insurance company is denying this for “coding issue” and “wrong place of service”. How can I appeal?

Answer:
CPT 30465 says “Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)” and was introduced into CPT in 2001 – 16 years ago – which is long before the injection procedure was performed. As a point of history, the code was valued to be a hospital/ASC services, has a 90-day global period, is inherently a bilateral procedure (meaning performed on both sides so modifier 50 may not be used), requires incisions and includes grafting as well as medial osteotomies when performed. Medicare’s physician time table says the code is valued for a median intra-service time of 120 minutes. We do not recommend using 30465 for the office procedure you describe. Rather, we recommend using an unlisted CPT code such as 30999.

*This response is based on the best information available as of 09/21/17.*
Moderate sedation Denials. How do we get paid for 99153?

September 7, 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.

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<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>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>
</tr>
</tbody>
</table>
When can I code an adrenalectomy?

September 7, 2017

Question:
I performed a laparoscopic adrenalectomy with a urologist who performed a laparoscopic radical nephrectomy. Do I code 60540 for the adrenalectomy?

Answer:
No, you are acting as a co-surgeon, since there is a CPT code that describes both your work and the work of the urologist. Code 50545-62 would be reported by you and by the urologist. Code 50545 describes a radical nephrectomy (included removal of Gerota’s fascia and surrounding fatty tissue, removal of lymph nodes and adrenalectomy.

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

Medicare Now Pays for Fluoroscopy with Some
Injection

September 7, 2017

Question:
I heard that Medicare now pays for fluoroscopy with some injection codes. Is that true?

Answer:
Yes, in 2017, fluoroscopy codes, codes +70002 and +77003 (see code descriptions below) have been revised and are now add-on codes. Under each code in the CPT manual, the primary codes these imaging codes may be used with are listed. These include some joint and nerve injections, among others. Medicare also deleted edits for these codes and the injection codes listed in the CPT manual. So Medicare will pay for the fluoroscopy. Make sure you document the imaging and retain a permanent image.

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<tr>
<td>+77003</td>
<td>Fluoroscopic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>+77003</td>
<td>Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid) (List separately in addition to code for primary procedure.)</td>
</tr>
</tbody>
</table>

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