Question:
If a thrombolysis infusion catheter is placed, can the catheterization (for example 36247) be billed in addition to the thrombolysis (37211)?

Answer:
Yes, the catheterization, (36245-36247) may be separately reported in addition to the thrombolysis code (37211). Remember, if a diagnostic angiogram is also performed, this may also be separately reported.

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

Assistant Surgeon Payments

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:
Without additional information it is difficult to respond to your inquiry. First, Medicare has a list of surgical CPT
codes where payment will be considered for an assistant surgeon. Some codes will be paid without documentation submitted, some codes will be considered for payment if documentation of medical necessity is present and other codes will not be considered for payment at all (e.g. when less than 5% of the codes have an assistant surgeon reported). It is helpful to review this as a first step to understanding the denial. If the code allows an assistant and the service is still denied, documentation needs to be reviewed. An assistant surgeon does not create a separate operative note for his/her role as an assistant. The primary surgeon is responsible for documenting the name and credentials of the assistant surgeon, and the work performed and medical necessity of the assistant must be documented in every operative note when services for the assistant are reported. Payors are no longer always paying claims when the assistant’s name is the only information reported.

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

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**Documenting time for moderate sedation in endoscopy: Is it Scope in to Scope out?**
Esophagoscopy and Glossectomy

October 19, 2017

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.

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

October 19, 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.

<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>
<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. <em>Use only for GI endoscopy procedures for Medicare patients.</em></td>
</tr>
</tbody>
</table>

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

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**Lumbar Stenosis Diagnosis Code**

October 19, 2017

**Question:**
I just received a claim denial because I used M48.06 (Spinal stenosis, lumbar region) as the diagnosis code. What’s the deal? I’ve been using this diagnosis code without a problem since ICD-10-CM started.

**Answer:**
Aha! There are new diagnosis codes for lumbar stenosis that
were effective October 1, 2017. The code M48.06 is no longer a valid diagnosis code. Instead, you’ll need to report one of the following 2 diagnosis codes:

- **M48.061**, Spinal stenosis, lumbar region without neurogenic claudication
- **M48.062**, Spinal stenosis, lumbar region with neurogenic claudication

Prior to 10/1/17, we did not have a single diagnosis code for lumbar stenosis with neurogenic claudication like we had in ICD-9-CM. However, this changed on 10/1/17 and now there is a code for lumbar stenosis with neurogenic claudication. The reason you experience the denial is because you used a code with 5 characters – M48.06 – which is now invalid. The lumbar stenosis codes now require a 6th character to represent the presence (or not) of neurogenic claudication.

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

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**EMG Guidance with Extremity Chemodenervation**

October 5, 2017

**Question:**
How many times can code 95874, Needle electromyography for guidance in conjunction with chemodenervation, be reported if chemodenervation is performed on four extremities (e.g.,...
64642, 64643, 64644, 64645)?

**Answer:**
Per CPT, code 95874 is reported for each corresponding chemodenervation of the extremity. In the example, four chemodenervation codes were reported, therefore, the needle electromyographic (EMG) add-on code 95874 would be reported four times for the scenario described in the question.

*Source: CPT Assistant October 2014*

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

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**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 “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 of 10/05/17.*