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.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
</tr>
</thead>
</table>

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

*This response is based on the best information available as of 09/07/17.*
Paramedian Forehead Flap on Previous Mohs Surgery

August 24, 2017

Question:
My doctor did a division and inset of a paramedian forehead flap on a patient that had Mohs surgery on their nose. Do I code 15620 since the flap was brought from the forehead, or 15630 since the flap was placed on the nose?

Answer:
Good question. If you look at the code descriptors, they state, “Delay of flap or sectioning of flap at…” This means that the code is chosen for where the flap is inset. In your case, the flap was inset at the nose. CPT code 15630 for division and inset at the eyelids, nose, ears, or lips, would be the correct code to report. Don’t forget also that if repair of the donor site requires skin graft or local flap to repair, it is separately reportable. Hope this helps.

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

Global Period for Surgery. Is
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 08/10/17.

---

Post-Op hemorrhage repair. Is it billable?

July 27, 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 07/27/17.*

**“Shave Technique”**

July 13, 2017

**Question:**
My physician documents a biopsy via “shave technique”. Is this the correct way to document a biopsy and report the procedure with 11100?

**Answer:**
We would encourage the physician not to use that term for a biopsy. CPT terminology for 11100 is “biopsy.” Furthermore, CPT uses the term “shave” as a method for removal (not biopsy) of a skin lesion and this is reported using the 11300-11312 codes. The point is that saying “shave biopsy” is confusing to payors and we discourage this language.

*This response is based on the best information available as of 07/13/17.*
Closure After Moh’s Surgery

June 22, 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 06/22/17.

Wound Debridement

June 8, 2017

Question:
My doctor’s operative note said he did a wound debridement of an ankle non-pressure ulcer (the patient is diabetic) “down to the muscle”. He wants to use 11043 (debridement including muscle) and I say it is 11042 (debridement of subcutaneous tissue). What do you think?

Answer:
Technically, the documentation should state “down to and including the muscle” to use 11043 because this code includes debridement of muscle. Saying “down to” the muscle does not specifically state muscle was actually debrided. So, we recommend 11042.

*This response is based on the best information available as of 06/08/17.

---

**Diagnosis Code for Flap Closure**

May 25, 2017

Question:
Can you help solve a diagnosis coding controversy we have? Occasionally, we have a patient who had a fracture and the Orthopedic Surgeon does the fracture repair. However, the Plastic Surgeon is asked to provide flap coverage to cover the open surgical wounds. What diagnosis codes should we use? I am thinking we use the fracture diagnosis code but we aren’t treating the fracture. Another coder says we should use an unspecified open wound code. We would appreciate your thoughts.
Good question! We agree that you would not use the fracture diagnosis code (S-) because you are not treating the fracture. We also would not use the S- open wound diagnosis code because the open wound was not caused by trauma — it is an open *surgical* wound. We recommend using and Z42.8 (Encounter for other plastic and reconstructive surgery following medical procedure or healed injury) as the primary diagnosis code. The fracture diagnosis code can be listed as a secondary diagnosis.

*This response is based on the best information available as of 05/25/17.*

---

**Exchange of Tissue Expander for Permanent Breast Prosthesis and Fat Grafting**

May 11, 2017

**Question:**
I placed a permanent breast implant after removing a tissue expander including a capsulotomy on the right side. At the same operative session, on the same side, I harvested fat from the thigh (via liposuction) and placed it in to the superior pole breast defect. These are the codes that I have picked: 19340 (immediate insertion of breast implant), capsulotomy (19370), 19380 (revision of reconstructed breast), 11954 (injection of the fat into the breast), 15877 (liposuction of the trunk), and 15879 (liposuction of the lower extremities).
Does this seem right?

Answer:
No, none of these are the right codes. The exchange of the tissue expander for a permanent implant requires a capsulotomy so the only code for that procedure is 11970 (not 19340, 19370, 19380). The fat grafting may be separately reported using 20926 which includes the harvest and placement/injection of the fat into the defect. So you’ll use only 11970 and 20926.

*This response is based on the best information available as of 05/11/17.

Assistant Surgeon Payments

April 27, 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.

*This response is based on the best information available as of 04/27/17.