Moderate Sedation Reimbursement Issues

During the past few weeks our consultants have received many questions about denials for moderate sedation. Additionally, some industry vendors have been distributing incorrect information about moderate sedation billing. For this reason we are reaching out to our clients to provide you with complete and accurate information about this issue.

CCI Edits

Some of the moderate sedation denials are due to Correct Coding Initiative (CCI) edits that incorrectly bundle the sedation into the procedure with which the sedation was provided. For example, the Q1 CCI edits bundle sedation codes 99151-99153 into dialysis circuit procedures (36901-36909), arterial and venous angioplasty (37246-37249), and intracranial thrombolysis (61645). These edits cannot be bypassed with a modifier. CMS is aware of this issue and intends to correct the edits in the April CCI release. For more information, see the following ACR article, which includes a list of all the affected codes.


MPFS Payment Indicators

The more significant issue has to do with the payment indicators CMS assigned to code 99153, which is the add-on code for each additional 15 minutes of sedation time by the physician performing the procedure. In the 2017 Physician Fee Schedule CMS assigned a PC/TC indicator of 3 to this code. This indicator designates code 99153 as a “Technical Component Only Code,” similar to code 93005 (EKG tracing without interpretation). Physicians are not reimbursed for codes with PC/TC indicator 3 in the hospital setting because these codes are classified as facility services that are payable only to the hospital. Code 99153 is the only moderate sedation code that has a PC/TC indicator of 3.

Additionally, CMS assigned code 99153 an “NA” indicator in the “Facility NA” field of the Physician Fee Schedule. According to the definitions CMS includes with the PFS Relative Value File, an “NA” indicator in this field “indicates that this procedure is rarely or never performed in the facility setting.” The other codes for moderate sedation by the same physician (99151 and 99152) do not have this indicator. Furthermore, the codes for moderate sedation by a different physician (99155-99157) actually have an “NA” indicator in the “Non-Facility NA” field, meaning that the procedure is “rarely or never performed in the non-facility setting.”

As a result of these payment indicators, when a physician provides sedation in the hospital setting for a procedure he or she is performing, the first 15 minutes (99151 or 99152) will be paid, but any additional time (99153) will be denied.
How to Bill?

If you have claims affected by the moderate sedation CCI edits, hold them until April 1 if possible, or plan on appealing the denial after April 1.

With regard to 99153, it appears CMS erred in assigning this code’s payment indicators. However, CMS has not yet announced any decision to change them. This has left many providers wondering whether they should write off the charges for hospital sedation time greater than 15 minutes. Furthermore, some industry sources have told providers that they are prohibited from billing for 99153 in the hospital setting.

Each practice must make its own decision on how to handle claims for 99153, but there are strong arguments for continuing to report all of the sedation codes in compliance with CPT® guidelines. Remember that CMS has now removed the payment for moderate sedation from those procedures that previously included it. This means your physicians will be underpaid for these services unless you bill the sedation separately. Continuing to code your sedation services correctly, consistent with CPT® guidelines, is not a compliance violation. Moreover, tracking the sedation time is essential because if CMS fixes the payment indicators for 99153, you will need to go back and re-bill or appeal your prior claims.

Watch for future communications from Coding Strategies concerning any new developments related to sedation billing.