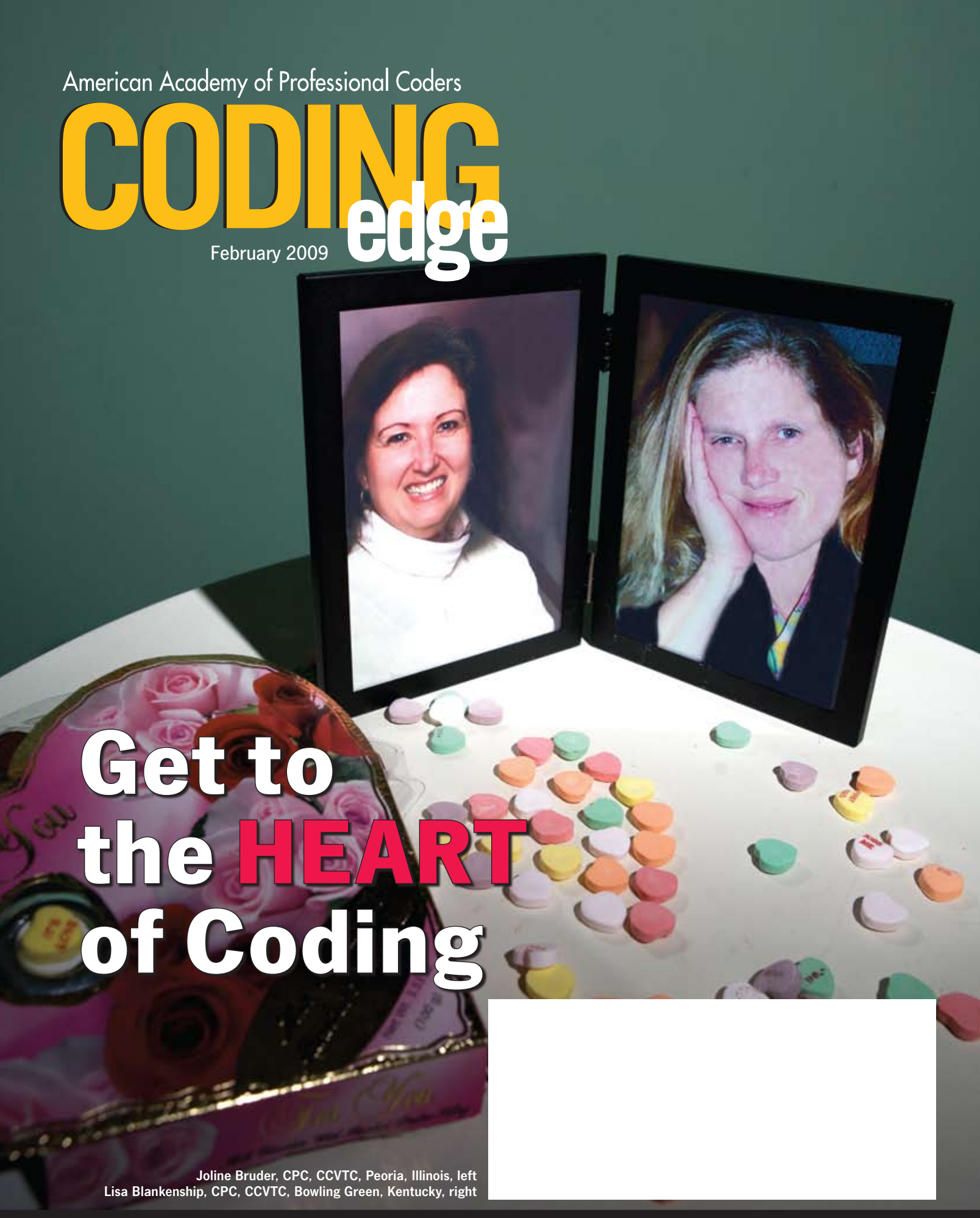
American Academy of Professional Coders

CODING edge

February 2009



Get to the HEART of Coding

Joline Bruder, CPC, CCVTC, Peoria, Illinois, left
Lisa Blankenship, CPC, CCVTC, Bowling Green, Kentucky, right

Plus: PQRI Results • Cardio Device Services • 2009 HCPCS Level II • Red Flags Rule • Hemorrhoids

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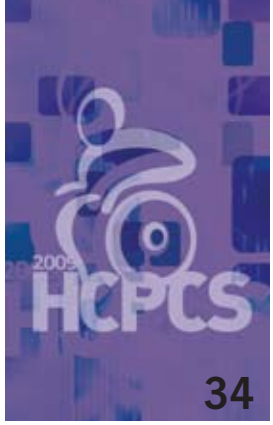

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Features

On the Cover: *February is a time of valentines, American Heart Month, talking about coding cardiovascular procedures, of candy, and a time to spot Joline Bruder, CPC, CCVTC, and Lisa Blankenship, CPC, CCVTC, members of the Cardiovascular and Thoracic Specialty Examination Committee.*
Photo by Candace Christensen, XPOSE Photography.

In Every Issue

Education

People

Coming Up

Liver Transplants
Anatomy
Modifier 25
Disaster Relief

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Targeting the AAPC Audience

The membership of AAPC, and subsequently the readership of *Coding Edge*, is quite varied. To ensure we are providing education to each segment of our audience, in every issue we will publish at least one article on each of three levels: apprentice, professional and expert. The articles will be identified with a small bar denoting knowledge level:

APPRENTICE	Beginning coding with common technologies, basic anatomy and physiology, and using standard code guidelines and regulations.
PROFESSIONAL	More sophisticated issues including code sequencing, modifier use, and new technologies.
EXPERT	Advanced anatomy and physiology, procedures and disorders for which codes or official rules do not exist, appeals, and payer specific variables.

AAPC Code of Ethics

Members of the American Academy of Professional Coders (AAPC) shall be dedicated to providing the highest standard of professional coding and billing services to employers, clients, and patients. Professional and personal behavior of AAPC members must be exemplary.

- AAPC members shall maintain the highest standard of personal and professional conduct. Members shall respect the rights of patients, clients, employers, and all other colleagues.
- Members shall use only legal and ethical means in all professional dealings, and shall refuse to cooperate with, or condone by silence, the actions of those who engage in fraudulent, deceptive, or illegal acts.
- Members shall respect and adhere to the laws and regulations of the land, and uphold the mission statement of the AAPC.
- Members shall pursue excellence through continuing education in all areas applicable to their profession.
- Members shall strive to maintain and enhance the dignity, status, competence, and standards of coding for professional services.
- Members shall not exploit professional relationships with patients, employees, clients, or employers for personal gain.

This code of ethical standards for members of the AAPC strives to promote and maintain the highest standard of professional service and conduct among its members. Adherence to these standards assures public confidence in the integrity and service of professional coders who are members of the AAPC.

Failure to adhere to these standards, as determined by AAPC, will result in the loss of credentials and membership with the American Academy of Professional Coders.

American Academy of Professional Coders

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Coding Edge
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Helping Hearts for Hope

Hearts, cardiology coding, and Cupid shooting arrows through hearts on Valentine's Day: that's what this February issue is about. I will share with you a trio of recent events within our AAPC family, coming from the heart.

First, this past Christmas, our national office employees did a little more to help those struggling this season. Last year, we chipped in for two "Sub for Santa" families. This year, our AAPC family did much more—we took on three Sub for Santa families and 34 recently arrived children from Nepal without a Christmas. For a few days, our office looked a lot like what we envisioned the North Pole to look like just before Santa took off in his sled. We packaged, labeled, and prepared more than 200 gifts for delivery. Almost 50 children and six adults were helped by our office of 75 employees. The hearts from both givers and receivers were filled with the joy of the season.

Second, we learned that two AAPC employees have breast cancer. When we found out, AAPC began selling white mugs with the pink breast cancer awareness ribbon on them to raise additional money for her rising medical bills. Many of you have already purchased one and we appreciate your heart's generosity. Just before Christmas, our employees donated thousands of dollars to help pay for the first wave of bills. Yes, insurance is picking up much of the tab for both … but not all. It was incredible, heartwarming, and gratifying to see the generosity and love people have for one another.

Third, my oldest daughter arrived at my home for the past Christmas holiday with her husband and two daughters, ages 3 and 1. Now there's nothing unusual about that. I noticed her 1-year-old had a huge smile on her face the entire 10 days she was with us. I swear she was the happiest child on earth. Why? I believe it's because she knows how lucky she is to be alive. She was born with two holes in her heart. Today, being born with a small hole (or even two) in your heart is not unusual. But her holes were large. How did we find out? The human body is so marvelous as it figured out what each organ should be doing and, in her case, her body slowed her growth when her heart could not keep up with a normal growing body's needs. Knowledgeable doctors at Stanford Medical Center found the holes with their advanced technology. At the age of 5 months, she went through five hours of open heart surgery, where surgeons lowered her body temperature, stopped her heart, connected her to bypass equipment, and repaired the holes, one by grafting other material and one by suture. She is still small, but growing and healthy.

The human heart is critical as it not only pumps vital nutrients to our entire body; it also represents the emotions enabling us to help others. Be grateful for our hearts and the wonderful cardiologists and surgeons who keep them working.

Sincerely,

Reed E. Pew
CEO and President

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Get to the Heart of the Matter

It's February, and everyone is getting ready for Valentine's Day—the day we let our loved ones know how special they are to us. A long time ago, people thought their emotions came from their heart—maybe because our heart beats faster when we're scared or excited. We give heart-shaped cards and eat heart-shaped candies on Valentine's Day; we cross our hearts; our hearts get "broken."

Hearts are a vital part of being

I like to think of the AAPC as the heart of our coding profession and its members as the organization's pulse. Without a pulse the heart would not function.

The AAPC has a responsibility to its members to promote ethical and professional coding, provide educational services to its members, and offer support to our profession. The AAPC has provided the "heart" to the coding profession for many years and has grown to be the largest professional coding organization in our country and beyond. We have more than 75,000 members and are still growing.

Together our pulse remains strong

As members, we have a responsibility to the AAPC and to our profession. We are responsible for maintaining the highest standard of personal and professional conduct, respecting the rights of our patients, physicians, employers, clients, and most importantly our colleagues. Above all, we must recognize each member's intrinsic worth.

To maintain a strong pulse and not develop cardiac dysrhythmia, members must support the organization with which they have chosen to partner. We might not always agree, but we are bound together with a common goal. To survive, we must respect the opinions of our colleagues and fellow members. It's great to circulate ideas, and the forums are an excellent place to share, communicate, and find answers to challenging questions among our AAPC family. Keep in mind, though, that negative responses and scathing comments about others weakens our pulse and damages the heart.

Recipe for maintaining a healthy heart:

- Exercise your brain regularly by attending coding education workshops and seminars.
- Get involved in your local chapter and "make a difference."
- Mentor a new coder and help with career development.
- Take time to learn a new specialty or skill.
- Support the AAPC by becoming involved.
- Volunteer and help others in need.
- Avoid negativity.
- Respect other members and their opinions and maintain a professional demeanor.
- Develop a personal mastery with integrity, openness, influence, and a mission that radiates from the heart.

Dare to bond, blend, and end unnecessary competition. Together, we have the potential to make one another stronger, smarter, and better than we are alone. Each and every member is the pulse of our organization. Do you have your finger on the pulse?

There are many things in life that will catch your eye, but only a few will catch your heart ... pursue those. —Michael Nolan

Until next month...

Deborah J Grider

Deborah Grider,
CPC, CPC-H, CPC-P, CEMC, CPC-I, CCS, CCS-P
National Advisory Board President

Bulletin Board

American Academy of Professional Coders

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FEBRUARY 2009

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
25	26	27	28 Audio Conference	29	30	31
1	2	3	4 Audio Conference	5	6	7
8	9	10	11 Audio Conference	12	13	14 Saint Valentine's Day
15	16 President's Day	17	18 Audio Conference	19	20	21
22	23	24	25 Audio Conference	26	27	28 Workshop

Help Fight Breast Cancer

Proceeds from the Coders for a Cure cup go to cancer awareness, care, and cure. Pick up yours at your local chapter meeting.

KUDOS!

Pat on the Back

We want to recognize our members' accomplishments. Have you had a recent promotion? Do you have a colleague who does wonderful things for the coding profession? Send your stories to Kudos@aapc.com.

WE SALUTE ★YOU!★

Are you a member who serves or has served in the military? Let us know if you are a coder whose coding has been affected by your experience while on duty. Send an email to michelle.dick@aapc.com.

★★★

Settle THE Payer vs. Provider Conflict

POINT/Counter-POINT

Are you a payer who has an ongoing conflict with a provider or is it the other way around? If you have an unsettled score to finish, we want to help you put your differences to rest. Send us your payer vs. provider issues at **michelle.dick@aapc.com** and we may feature them in our Point/Counterpoint column.

Local Chapter Welcome Wagon

How does your local chapter welcome newbies? Do you have an interesting way to welcome new chapter members without scaring them away? If so, send your ideas to michelle.dick@aapc.com.

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Policy forms issued in Oklahoma include: Comprehensive PPO-GR-11741 (5/04), Limited-GR-11741-LME (5/04) and Dental-11826 Ed 9/04.

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Letters to the Editor

ASC Urology Ambiguity Needs Clarification

Dear *Coding Edge*,

In the December 2008 *Coding Edge*, Paul Cadorette's article "Ring in the New Year with Proper ASC Urology Coding" states, "It's appropriate to report one CPT® code for each different category of bladder tumors based on their size: small, medium, or large." Please see the information below from the Medicare Claims Processing Manual where it indicates only one code for the largest size may be submitted.

Chapter 12–Physicians/Nonphysician Practitioners

30—Correct Coding Policy
30.2—Urinary and Male Genital Systems (Codes 50010 - 55899) (Rev. 1, 10-01-03)
B3-15200

B. Cystourethroscopy With Fulgration and/or Resection of Tumors (Codes 52234, 52235, and 52240)

The descriptors for codes 52234 through 52240 include the language "tumor(s)."

This means that regardless of the number of tumors removed, only one unit of a single code can be billed on a given date of service. It is inconsistent to allow payment for removal of a small (code 52234) and a large (code 52240) tumor using two codes when only one code is allowed for the removal of more than one large tumor. For these three codes only one unit may be billed for any of these codes, only one of the codes may be billed, and the billed code reflects the size of the largest tumor removed.

Anonymous auditor

Dear Anonymous,

Coding is dependent upon whether you are billing per AMA guidelines for a commercial carrier or CMS guidelines for a Medicare patient—there can be stark contrasts between the sets of guidelines. Per *CPT® Assistant* fulguration of multiple tumors may be reported one time by size. (AMA Guideline) Medicare guidelines differ. The information in the article pertains to coding for ASC Facility Services (Chapter 14) of the *Medicare Claims Processing Manual*. Physician services may be bound by different guidelines also.

October 2002, page 12
Coding Consultation: Surgery-Urinary System, 52234 (Q&A)

Question

When multiple bladder tumors are fulgurated or resected using a cystourethroscope, how is the size category determined? We have been advised to add all the tumor sizes together and report the total as small, medium or large. Is this correct?

AMA Comment

The tumor sizes should not be added together for a cumulative total size. Rather, each tumor should be measured individually to determine the appropriate category (eg, small, medium, large). Code **52234**, *Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 to 2.0 cm)*, should be reported once for single or multiple tumors that individually measure 0.5-2.0 cm. Code **52235** should be reported once for medium (single or multiple) tumors that individually measure 2.0-5.0 cm. Tumors larger than 5.0 cm would be considered large tumors and would be reported using code **52235** one time.

Paul Cadorette
CPC, CEDC, CPC-H, COSC, CPC-P, CASCC
Director of Education, mdStrategies

Dear Paul,

I understand what you are saying; however, since we are supposed to "bill everyone the same way," I don't really think there is any distinction between Medicare billing and commercial billing except in specific circumstances. Back to the whole "billing each urology code for each size tumor," if you submit 52234, 52235, and 52240 in any combination of a lesser size, it triggers OCE edit 20 which indicates that the lesser code is considered a component of the comprehensive code and is not allowed even with an appropriate modifier. I think that ASCs will also be subject to the OCE as they are now being paid similar to OPPS.

Anonymous auditor

Dear Anonymous,

See www.lamedicare.com/provider/medguide/corrcoding8.pdf.

Correct reporting of bladder tumor removal: The following is a usage explanation of CPT® codes 52234-52240, cystourethroscopy with fulguration and/or resection of bladder tumor(s):

Use of the appropriate code is based on the size of the tumors being removed. For example, if there are three tumors that are different sizes, then one number of service for each code should be reported as follows:

1) 52234 small tumor

2) 52235 medium tumor

3) 52240 large tumor

If there are multiple tumors being removed of any one size, report only one number of service. For example, if three large tumors were removed, submit code 52240 x 1. Remember, the code description states "tumor(s)," which means tumor or tumors.

Paul Cadorette
CPC, CEDC, CPC-H, COSC, CPC-P, CASCC
Director of Education, mdStrategies

By Belinda Frisch, CPC, CEMC

coding news

IPPE 2009 Update

The Centers for Medicare & Medicaid Services (CMS) announced effective Jan. 1, the Initial Preventive Physical Examination (IPPE) benefit has expanded to include the following:

- Measurement of BMI
- End-of-life planning (upon individual consent)
- The electrocardiogram (EKG) component, formerly mandatory, performed or ordered in conjunction with the IPPE is no longer required, but may be ordered as a one-time optional benefit.
- The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) made two other significant changes:
- The deductible is waived for IPPE code G0402. Coinsurance (20 percent) applies.
- IPPEs formerly covered within six months of enrollment in Medicare Part B are now allowed within 12 months of enrollment.

2009 Codes for the IPPE and EKG are as follows:

G0402 IPPE; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment

G0403 Electrocardiogram, routine ECG with 12 leads; performed as a screening for the IPPE with interpretation and report

G0404 Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the IPPE

G0405 Electrocardiogram, routine ECG with 12 leads';interpretation and report only, performed as a screening for the IPPE

CMS allows for a medically necessary evaluation and management (E/M) service when provided during the same visit as an IPPE. CPT® codes 99201-99215 may be reported with modifier 25 *Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other Service* when appropriate and supported by documentation.

Because IPPEs are frequency-limited, conditionally-covered services, an Advance Beneficiary Notice (ABN) should be issued to the patient prior to the examination making them aware of their potential financial responsibility.

Denial code 20.91 *This service was denied. Medicare covers a one-time IPPE if you get it within the first 12 months of the effective date of your Medicare Part B coverage* will be listed on the Medicare Summary Notice (MSN) when claims with G0402 additional beyond the first IPPE are received.

Belinda S. Frisch, CPC, is author of Correct Coding for Medicare, Compliance, and Reimbursement, and resides in upstate New York. She can be reached at BFrischCPC@nycap.rr.com.

PQRI:

2007 Results Prompt Changes

First-year results prompt changes to the heart of the program.

By Julie Orton Van, CPC, CPC-P

The first year's results for the Physician Quality Reporting Initiative (PQRI)—the initiative to incent the use of and track standard quality initiatives—reflect the influence of a complicated new recipe. Not all chose to try it, and of those who did, only half found success. After such a start, how does a practice make PQRI participation worth the effort?

According to Centers for Medicare & Medicaid Services (CMS), data from 2007 showed approximately 16 percent of eligible professionals participated in the program. Of those who participated, just over half were successful in meeting the program and reporting requirements and, as a result, qualified to receive an incentive payment. Nationally, 109,349 National Provider Identifier/Taxpayer Identification Number (NPI/TIN) combinations (15.8 percent of eligible NPI/TIN combinations) submitted at least one quality data code (QDC).

The CMS collected quality information for services furnished from July 1, 2007 through Dec. 31, 2007. CMS paid $36 million in incentive payments to health care professionals who met the criteria for satisfactorily reporting data during the 2007 PQRI. These incentive payments were sent out starting in July 2008. So far, the average individual eligible professional incentive amount is more than $630. The largest incentive payment for a group practice is $205,795, and the average incentive is $4,713. To be eligible for an incentive payment, health care professionals are generally obligated to report at least three quality measures for at least 80 percent of the cases in which the measure was applicable. The 2007 budget for the PQRI was $150 million, meaning more than $114 million was not reimbursed.

CMS is not only looking closely at the mixed results of the program, they're sharing information that will help us succeed.

Valid Claims

For a valid claim submission, the QDC reported must apply to the patient according to the measure specifications (age, gender, diagnosis, and procedure). The claim must also include the rendering professional's NPI, and otherwise comply with PQRI QDC submission business requirements. Of those 109,349 NPI/TIN combinations

- 92.5 percent validly submitted at least one QDC;
- 64 percent validly reported quality data on 80 percent of eligible cases for at least one measure; however, many didn't earn an incentive because they didn't meet the criteria for satisfactory reporting;
- 52 percent earned an incentive payment (met satisfactory reporting criteria by reporting data on one to three applicable measures for 80 percent of applicable cases); and
- 1 percent was subject to the cap while the rest qualified for the full 1.5 percent incentive payments.

A total of 14,089,837 QDCs were reported:

- 51.6 percent were submitted validly
- 48.4 percent were submitted invalidly

In the Dec. 3, 2008 CMS publication *Physician Quality Reporting Initiative (PQRI) 2007 Reporting Experience*,

Valid reporting could only be determined if the QDC was submitted on the same claim as the associated measure's billing and diagnosis code(s)

CMS said that since it began accepting the quality data in July 2007 for the 2007 PQRI, it identified and began to remedy issues and questions raised about the 2007 PQRI results and feedback. CMS result analysis of the completed first cycle of reporting has identified unanticipated issues they believe may have impacted physicians and other professionals' success in meeting reporting quality data program requirements. These issues, which are outlined in more detail in the report, include claims-based reporting mechanisms issues, NPI numbers not included on the claims forms, incorrect quality reporting data or claims submission errors, and the feedback reports' content.

Valid quality data reporting could only be determined if the measure specifications were adhered to. Based on the CMS review, the following invalid quality data submissions were caused by eligible participants (EPs) failing to adhere to measure specifications when submitting QDCs and denominator codes, which were established through a board consensus process that included the physician community.

- *Incorrect HCPCS denominator code:* 18.9 percent. A QDC was submitted and a HCPCS (CPT® or HCPCS Level II) denominator code was submitted, but the HCPCS code submitted was not one that was appropriate for the measure. Each measure requires submission of a HCPCS (procedure or service code). A measure that had a high reporting error due to this reason was measure No. 30 (Perioperative Care: Timing of Prophylactic Antibiotic—Administering Physician). This was the only measure requiring the submission of a CPT® Category II code for the denominator rather than a HCPCS Level II procedure or service code.
- *Incorrect diagnosis code:* 13.9 percent A QDC and a diagnosis code were submitted, but the diagnosis code was not the diagnosis appropriate for the reported measure. Incorrect diagnosis reporting rates were high for measures requiring multiple diagnoses, eg, No. 5 (Heart failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction), and no. 8 (Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction).
- *Incorrect HCPCS and diagnosis code*: 7.2 percent. A QDC was submitted and a HCPCS code and diagnosis code were submitted, but neither the HCPCS nor the diagnosis code is in the reporting denominator for the applicable measure's QDC. A measure with a high reporting error due to this reason was measure No. 7 (Beta Blocker Therapy for Coronary Artery Disease Patients with Prior Myocardial Infarction). This measure required the reporting of an ICD-9-CM diagnosis code to identify patients with a coronary artery disease diagnosis and a MI diagnosis and a CPT® service code for the denominator.
- *Incorrect age*: 6 percent. The QDC was submitted for a patient outside of the measure's age parameters. Many measures are limited by age parameters. Those that only apply to the pediatric or younger adult age population experience very high error rates, eg, measures no. 53 (Asthma; Pharmacologic Therapy for Ages 5 to 40), and no. 64 (Asthma Assessment for Ages 5 to 40). Even those with upper age ranges of age 75, such as the diabetes measures No. 1 (Hemoglobin A1c Poor Control in Type 1 or 2 Diabetes Mellitus for Ages 18 to 75), No. 2 (Low Density Lipoprotein Control in Type 1 or 2 Diabetes Mellitus for Ages 18 to 75), and No. 3 (High Blood Pressure Control in Type 1 or 2 Diabetes Mellitus for Ages 18 to 75), experienced large error rates.
- *Incorrect gender*: 2 percent. The wrong patient gender was submitted for the measure's QDC. Only a few measures are limited by gender, eg, measure no. 39 (Screening or Therapy of Osteoporosis for Women Aged 65 Years and Older).

Claims Submission/Split-Claims Errors

Valid reporting could only be determined if the QDC was submitted on the same claim as the associated measure's billing and diagnosis code(s). In searching for technical issues to explain a portion of the invalid QDC submissions, we separated QDCs that were submitted invalidly because of missing HCPCS codes, not just an incorrect HCPCS code as described above. This was done because a missing HCPCS code could be an indicator that the claim was split (for example, separated into smaller claims) prior to submission or during the carrier or MAC claim processing; the initial single claim would

have arrived in the claims data file used for the PQRI determinations as multiple claims.

CMS found that 6.3 percent of QDCs had no HCPCS codes on the claim. When claims are split prior to submission to the carrier or MAC by the EP's billing software or clearinghouse software, there isn't an identifier on these claims indicating that they were originally part of a single claim. For analysis purposes, it was assumed these split claims were separate, unrelated claims. To identify these circumstances they reviewed all claims containing only QDCs to determine if there were other claims with HCPCS codes for the same beneficiary, service date, TIN, and NPI. The 6.3 percent of QDC submissions without HCPCS on the claim can be broken out even further below:

- *Only QDC on claim:* 5 percent. A QDC was submitted on a claim, but there wasn't a HCPCS code on the claim to determine the measure's appropriate denominator population. All measures must contain at least one HCPCS code in the reporting denominator.
- *QDC and incorrect diagnosis code on claim:* 1.3 percent. A QDC was submitted on a claim, but there wasn't a HCPCS code on the claim and the diagnosis code reported wasn't the required diagnosis code for the measure's denominator population. All measures must contain at least one HCPCS Level II code in the reporting denominator. However, not all measures require a diagnosis code to determine the denominator population.

CMS found that for the 32.8 percent of claims with only QDCs, they could match the claim with another claim containing a HCPCS code and diagnosis code with the same patient identifying information and service date. CMS estimates this technical issue's impact as 2 percent overall. This could affect professionals who otherwise would have qualified for satisfactory reporting for 2007.

CMS was aware when developing 2007 analytics that in some cases carriers/MACs split claims for processing. To account for this, their contractor established a routine for 2007 analysis to reconnect these split claims; however, the routine was limited to claims containing 13 or more line items. In conducting a recent review, they found 2.4 percent of claims with only QDCs present had been split by the carrier/MACs. This amounts to only 0.2 percent of QDC submissions. Now that they are aware of claims with fewer than 13 lines being split by carriers/MACs, they will modify analytics for the 2008 PQRI program and future years' programs to reconnect any claims split by carriers/MACs.

No NPI on the Claim

In some cases, the business rule requiring the NPI for valid quality data submission and analysis had an impact on determining whether an EP satisfactorily reported. A total of 12.2 percent reported did not include an NPI on the line where the QDC was reported. Lack of an NPI on the claim or line may have been caused by the EP's failure to include it in their billing software or clearinghouse software.

When reviewing the missing NPI issue, CMS tracked representative cases from the initial claim all the way to the claims warehouse, the database used for the satisfactory reporting determination, and the incentive payment calculation. They have not encountered NPI mishandling once the NPI was received by the carrier/MAC in the appropriate place on the claim (ie, as the rendering NPI for the HCPCS and QDC line item codes). They did, however, encounter situations where EPs' electronic data interface software or clearinghouse processes led to not submitting or incorrectly submitting NPIs (such as transposing the NPI from the line item to the referring NPI field). In these circumstances, the requirement of the NPI appearing on the line item for the HCPCS Level II and QDC was not met.

Other Unsatisfactory Reporting Issues

When conducting additional reviews of the data submitted for the 2007 reporting period, CMS found a data issue involving claim types for certain durable medical equipment (DME) items included in the 2007 analysis. In the preliminary review, particular claims which were submitted correctly by EPs to the carrier/MAC and sent on to the National Claims History (NCH) system also included data elements (HCPCS codes, diagnosis codes and the EP's NPI), giving the appearance of claims that should have a QDC included for a measure. CMS did not adjust for these claims in the analysis for 2007, so they were included. Consequently, this may have caused a falsely inflated measure for an affected EP's denominator population, potentially resulting in the EP's unsatisfactory reporting a 2007 measure and not being eligible for an incentive payment.

Participant Feedback

CMS received concerns about difficult-to-access or complicated feedback reports. Others have asked for more frequent reports. They are investigating other avenues to help EPs access the reports, but they do not expect to make any changes impacting physicians and professionals who have already established security accounts.

As for report substance, some professionals found the reports contained too much information. In response to these comments, CMS will simplify the reports and plans to list only measures the EP actually submits. They will also provide more detailed information to help submitters understand the submitted data analysis.

CMS agrees that using more frequent and up-to-date reports would be helpful; however, they face certain practical limitations that make it difficult to achieve that goal. After a reporting period closes, there is a time lag to allow for completion of submitted claims. Where possible, they will provide information about reporting errors.

Keep Moving Forward

CMS has put together an education and outreach plan allowing EPs and their staffs to easily obtain information about the PQRI program. For the 2009 program, CMS will do the following:

- Conduct monthly National Provider Calls focusing on important topics for reporting 2009 programs' PQRI measures.
- Update and expand the frequently asked questions available on CMS' PQRI Web site at www.cms.hhs.gov/PQRI.
- Post the updated measure specifications used in the 2009 program.
- Develop and post updated tip sheets and fact sheets for the 2009 program to assist EPs in reporting quality data to CMS by the claims-based system or through qualified registries.
- Conduct more educational sessions with the carriers/MAC contractors.
- Continue to provide speakers at local, regional, and national conferences on PQRI topics. CMS regional office staff will also continue to be a resource to EPs in providing assistance, education, and outreach activities at the local level.
- Develop a Web-based education course on PQRI and the E-Prescribing Incentive, offering continuing medical education credit to EPs (a new activity for 2009).
- Actively partner with the American College of Physicians and the American Academy of Family Physicians to conduct and develop additional education and outreach materials/activities to increase participation in PQRI.
- Widely share information learned from the 2007 program experience.

You can find more information about the 2007 PQRI experience by going to the CMS Web site at www.cms.hhs.gov/PQRI/Downloads/PQRI2007ReportExperience.pdf. CE

Coding Edge—sidebar

Don't Wait For CMS' PQRI Feedback

As noted in a recent article, "New AMA Survey Highlights Need to Improve Medicare's PQRI," posted on the American Medical Association's (AMA) Web site (www.ama-assn.org/ama/pub/category/20208.html), "Key elements of Medicare's Physician Quality Reporting Initiative (PQRI) must be improved so that physicians can successfully participate and use the information to increase the quality of patient care. This is the main takeaway from the AMA new survey of physicians who participated in the PQRI during its first year of implementation."

According to AMA board member Ardis Hoven, MD, more than six out of 10 physicians surveyed rated the program difficult and only 22 percent were able to download the PQRI feedback report for their practices. Hoven said, "Physicians who began reporting in July 2007 did not receive a feedback report until 12 months later, halfway through the program's second year, making it impossible to fix any reporting problems. This may have contributed to the fact that nearly half of all PQRI participants did not receive any bonus payment. If reforms are not made to the program, physicians who participate in 2008 will not receive feedback reports until 18 months after initial reporting."

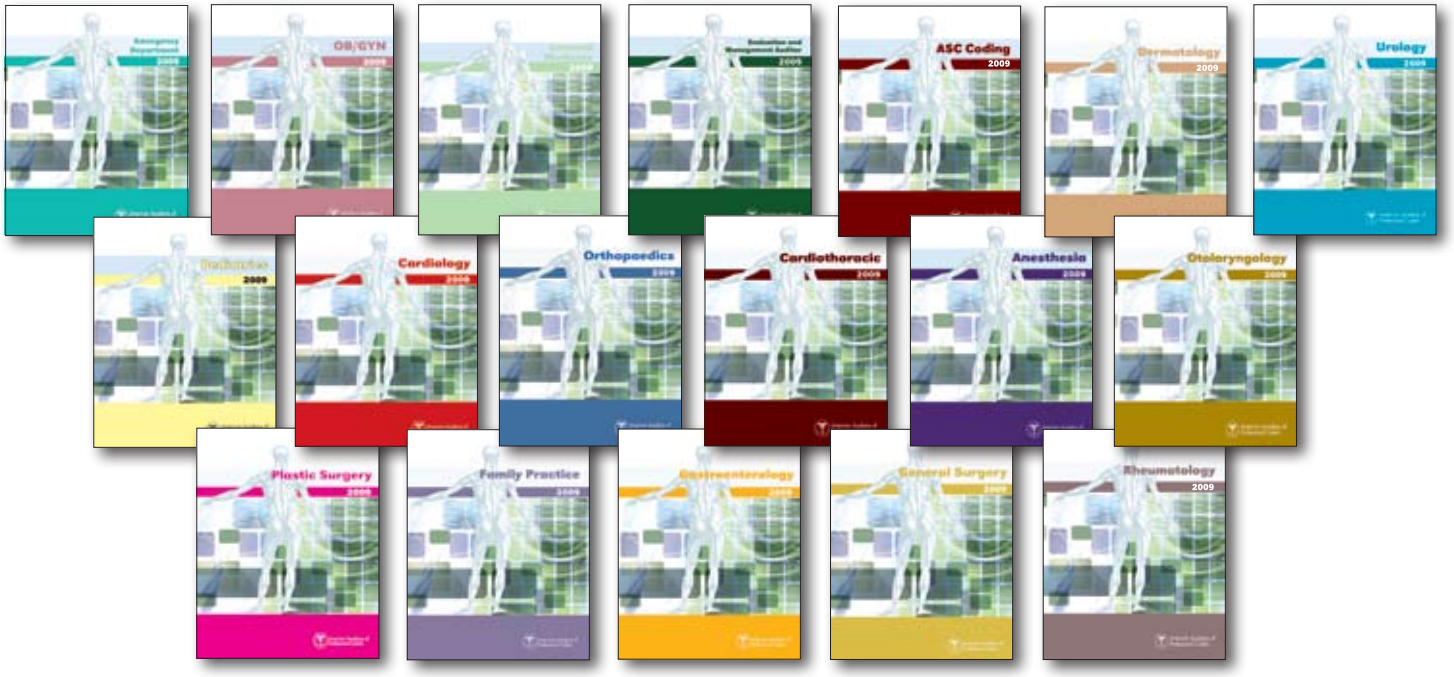
Advice for Successful Reporting

According to successful PQRI participants, you should never wait for the Centers for Medicare & Medicaid Services (CMS) to report back to you. All successful practice members whom I spoke with stressed the need to institute a closed-loop process for reporting PQRI quality data codes (QDCs). What this means is for every claim you submit with PQRI data, you need to track whether or not CMS acknowledged the data and validated it toward your successful reporting percentage.

For every quality measure submitted on a claim, CMS will reject that line with rejection code N365 if it was accepted into the PQRI data base. You'll know a measure was not successfully accepted by CMS if you do not see rejection code N365 on your remittance advice for claims you thought you reported QDCs. Each instance of the "missing" rejection code needs to be examined and researched. This is the only way you can identify what you are doing wrong in a timely manner. Once you determine what you were doing incorrectly, immediately make the necessary changes in your reporting process. Validating in this manner is really no different than reconciling your accounts to contractual terms for private payer contracts. You definitely do not want to wait for CMS or any other payer to report this to you 18 months after the fact.

—Julie Orton Van, CPC, CPC-P

Julie Orton Van, CPC, CPC-P, works at Ingenix as a product manager. She has more than 25 years experience in the health care industry, including physician practice administration, home health and hospice, managed care, laboratory services, contract and benefits administration and clinical information systems. Julie can be reached at Julie.Van@Ingenix.com.



Specialty Credentials
Made Heartier for 2009

By Michelle A. Dick, senior editor

AAPC specialty credentials mean more than ever thanks to recast, real world specialty exams and on-line practicums developed to gauge the superior level of expertise required to code each specialty.

Better Test of Specialty Expertise

The specialty exams' new format reflects actual specialty coding scenarios. The AAPC's Director of Exam Content, Raemarie Jimenez, CPC, told *Coding Edge*, "The specialty exams are operative note and office note based. Each note is followed by coding questions pertaining to the note. All operative notes and office notes were provided by coders in each specialty."

According to Sheri Poe Bernard, CPC, CPC-H, CPC-P, AAPC's vice president of clinical coding content, "This allows for a better understanding of the examinee's coding knowledge for a specialty. The answer format is different too. In most cases, each answer is separately broken out. For example, 'What is the first listed CPT® code? What is the second listed CPT® code?' Those are separate answers, different from the CPC® exam, which lists a series of codes with each answer and the examinee picks the correct series."

It was important to change our specialty exams and "to strengthen the content of the exams so they truly measure a coder's expertise. With a change in the prerequisites (no CPC® is required to sit for the new specialty exams) we wanted to ensure the tests were robust and complete," Bernard said.

Jimenez said, "We changed the development and format of the exams to simulate 'real world' coding. It was important to get the consensus from experienced coders in each specialty on the procedures and diagnoses codes. Our goal for the new specialty credential is to show employers the coder is proficient in her specialty."

2009 changes to specialty certification include:

- ❑ Specialty credentials are stand alone certifications with no requirement to hold a CPC®, CPC-H®, or CPC-P® credential (please note the name change for credentials listed in the table below)
- ❑ Exams more aptly measure preparedness for real world coding by being operative and patient note-based
- ❑ Exams are 5 1/2 hours in length (one free retake is included)
- ❑ 150 multiple choice questions (proctored)
- ❑ Exam preparation is available through online operative and patient note-based distance learning practicum

Real World Coding Means Real World Approach

Committees made up of expert members from every specialty field provided real operative reports for the exams and practicums. Jimenez explained, "A specialty committee of four to five coders with expertise in their specialty was formed to assist with each specialty exam's development. The committee started the process by determining test criteria that included the most common procedures performed and diagnoses coded in the specialty as well as coding challenges unique to each specialty." The tests were written to best gauge examinees' specialty expertise. The exam committees went the extra-mile to ensure exam questions reflect the skills needed in each specialty area.

All exams have 150 questions. "Each note was reviewed by the committee. A consensus was reached by the committee on the questions and answers for each exam," Jimenez said, "The committee determined the criteria for the exam based on commonly coded cases covering CPT®, ICD-9-CM, and HCPCS Level II coding common in each specialty."

Bernard added, "For example, the criteria for the cardiothoracic exam included an understanding of how to code a video-assisted surgery converted to an open surgery." Other general criteria included "core coding and compliance knowledge, such as; modifier use, code selection, sequencing, guidelines, medical terminology, anatomy and physiology, reimbursement, and regulatory concepts.

"We used 'in the trenches' coders for test development and beta-tested the exams to a very select group of specialty coders."

Specialty Practicum Goes Extra Mile

Each specialty has an online practicum replacing the printed study guides of the past, and each practicum can be completed at www.aapc.com, similar to the CPC® practice exams. Because the specialty exams were changed, it was important to update the specialty guide practicum to reflect the exams. Bernard said, "The online format and the multi-media approach to learning will enhance each student's experience. We also believe the pre-test will accurately gauge a person's readiness for the exams."

Each specialty practicum contains the following:

- ❑ 75 practical case study exercises from actual medical documentation (rationales included with answer submission)
- ❑ One-hour audio lecture on Evaluation and Management (E/M) coding
- ❑ (Ambulatory surgery center (ASC) coders will have alternative audio lecture in place of the E/M topic.)
- ❑ One-hour audio lecture on procedural coding specific to the specialty
- ❑ One-hour audio lecture on diagnoses coding specific to the specialty

The practicums are high-level pass/fail courses, so expertise in medical terminology, anatomy, and coding knowledge is strongly recommended. Each is worth six continuing education units (CEUs) upon completion. It's formatted like the specialty exam and includes rationales for each operative note and office note. "Completion of the practice exam gives the examinee an idea if he or she is prepared to sit for the exam. For the notes coded incorrectly, the examinee is given direction for proper coding in each rationale. After completing the practice exam, the examinee will know what to study to prepare for the exam. The online format makes it accessible to many examinees," Jimenez said.

Find Credentials in Your Specialty

Specialty practicums are available starting in January. The new credentials, which reflect their stand-alone nature, are as follows: (Existing specialty certified members will be grandfathered and receive an updated certificate in January).

Anesthesia and Pain Management	**CANPC**
Cardiology	**CCC**
Evaluation and Management	**CEMC**
Family Practice	**CFPC**
General Surgery	**CGSC**
Obstetrics/Gynecology	**COBGC**
Orthopaedics Surgery	**COSC**
Ambulatory Surgical Center	**CASCC**
Cardiovascular and Thoracic	**CCVTC**
Dermatology	**CDERC**
Emergency Department	**CEDC**
Internal Medicine	**CIMC**
Otolaryngology	**CENTC**
Pediatrics	**CPEDC**
Gastroenterology	**CGIC**
Plastic and Reconstructive	**CPRC**
Rheumatology	**CRHC**
Urology	**CUC**

Check www.aapc.com for the availability dates.

[Michelle Dick is senior editor of *Coding Edge*]

Red Flags Rule Protects Patients

FTC Rule on Identity Theft Impacts Providers

By David N. Anthony, Paige S. Fitzgerald, and Erin S. Whaley of Troutman Sanders LLP, Richmond, Va.

Identity theft is a significant and growing problem. According to a study released in February 2007, identity theft increased 50 percent from 2003 through 2006 with more than 15 million Americans victims of identity theft in 2006 alone. In response to these staggering figures and in an effort to prevent and combat this crime, the Federal Trade Commission (FTC) and other federal agencies issued regulations affecting financial institutions and creditors—common witnesses to identity theft.

The Red Flags Rule, issued November 2007, requires financial institutions and creditors to develop and implement written identity theft prevention programs in connection with the Fair and Accurate Credit Transactions (FACT) Act of 2003. These regulations necessitate the identification, detection, and response to patterns, practices, and specific activities indicating identity theft in a formal program.

Clear Up Any Confusion

Many health care providers have asked whether the Red Flags Rule applies to them. Not surprisingly, health care providers typically do not consider themselves financial institutions or creditors and do not generally fall under FTC rules. As a result, most providers paid little attention to the Red Flags Rule program's initial compliance implementation date of Nov. 1, 2008. Health care providers were not the only businesses with questions about the Red Flag Rule. A few days before the original compliance date, the FTC decided to delay enforcement of the Red Flags Rules for six months until May to give financial institutions and creditors additional time to develop and implement written programs.

The FTC's broad preliminary interpretation of "creditor" within the Red Flags Rule means any business offering services not paid in full at the time of the provision of services. This definition would expand coverage far beyond traditional lenders, such as banks, finance companies, mortgage brokers, automobile dealers, telecommunications companies, and utility businesses.

Health care providers clearly are not financial institutions, but many are creditors under the FTC's broad definition. The FTC explained "health care providers are creditors if they bill consumers after their services are completed" (www.ftc.gov/bcp/edu/pubs/articles/art11.shtm).

For instance, if a health care provider collects a co-payment at the time of service, submits a claim to the patient's insurance company, receives payment from the insurance company, and then bills the patient for any remaining amounts owed, the provider is a creditor under the Red Flags Rule. Similarly, if a provider allows patients to pay their accounts on a monthly basis, the provider is a creditor.

Given confusion on how the Red Flags Rule applies to health care providers and the potential steps to take and expenses to pay for compliance, the American Medical Association (AMA) and 27 other specialty medical organizations sent a detailed letter on Sept. 30, 2008 to the FTC chairman (www.ama-assn.org/ama1/pub/upload/mm/31/ftc_letter20080930.pdf). The AMA's letter objected to the FTC's Red Flags Rule applying to health care providers and asked for clarification. The FTC has not responded formally to the AMA's letter, and has not indicated intent to do so. Because the FTC's intention is unclear, health care providers should continue their efforts to comply with the Red Flags Rule by the May 1 deadline. If providers do not, they risk fines from the FTC of up to $2,500 per offense according to 15 U.S.C. § 1681s.

Take Steps to Comply

The Red Flags Rule outlines necessary and specific steps for providers to take to create an identity theft protection program for compliance. First, the provider should conduct a risk assessment to identify their vulnerabilities. The risk assessment should examine, among other things.

- the procedures the provider uses to open its accounts;
- the procedures the provider has for allowing access to accounts (such as password protections, etc);
- the provider's previous experience (or lack of experience) with identity theft; and
- identification of potential red flags.

A *red flag* is a pattern, practice, or specific activity indicating the possibility of identity theft. Typical medical identity theft warning signs concerning health care providers include:

- records showing medical treatment that is inconsistent with the patient's history;
- suspicious documents, such as a forged insurance card;
- a patient who has an insurance number but not a card or documentation; and
- unusual billing patterns.

After conducting an initial risk assessment, the Red Flags Rule requires health care providers to establish a formal, written identity theft program. Many health care providers may need to modify existing policies and procedures for protecting the privacy and security of health information. For instance, the Red Flags Rule requires health care providers to identify a "red flags manager." A health care provider may choose to expand the scope of a privacy, security, or compliance officer to include new red flags responsibilities instead of establishing an entirely new position.

The Red Flags Rule requires four basic elements to be present in an identity theft program. They are

- identify relevant red flags of identity theft and incorporate those into the program;
- detect of red flags in connection with the customer accounts;
- respond appropriately, commensurate with the degree of risk posed, to any red flags detected by the health care provider so identity theft will be mitigated and prevented; and
- ensure the program is updated periodically, taking into account changes in circumstances.

While an identity theft program must have these four elements, like the Health Insurance Portability and Accountability Act (HIPAA), the Red Flags Rule gives health care providers flexibility to design an appropriate identity theft prevention program for the provider's size, complexity, and unique circumstances.

Once the health care provider completes a risk assessment and finalizes a program, the provider's board of directors, an appropriate board's committee, or designated senior level manager must formally adopt the program. The provider must train staff to effectively implement the program and to periodically update the program. The Red Flags Rule also contains an explicit requirement that an annual report (or a more frequent report) be prepared for the board or a designated senior level management employee evaluating the effectiveness of the Red Flags program. The report should address identity theft risks when opening covered accounts and any significant identity theft incidents for existing covered accounts, management's response, and any recommendations for material changes to the program.

Target Medical Identity Theft

The Red Flags Rule may have other significance to health care providers besides identify theft to patient's financial accounts. Health care providers also need to be aware of medical identify theft, as issued in 72 Fed. Reg. 63,727 (Nov. 9, 2007). The consequences of theft and misuse of health care records can be as severe as the theft of an individual's financial records. Medical identity theft causes not only financial difficulties but has the potential to cause physical harm to its victims. Given the increasing economic and government pressure on health care providers to adopt electronic billing and medical records systems over the past decade, health care providers have become a target-rich environment for identify theft criminals. A health care provider's best practices should include instituting a program to guard against identity theft and protect the provider and patients.

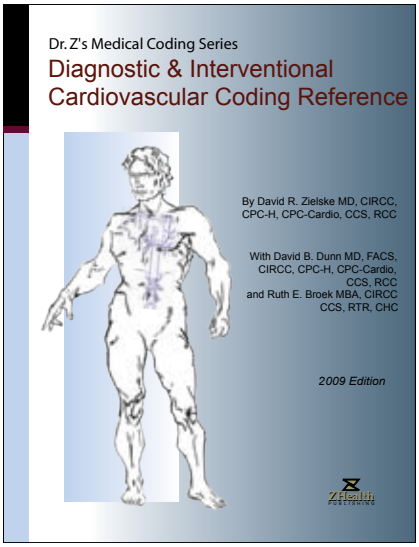
The Red Flags Rule requires creditors to develop an identity theft prevention program tailored to their unique situation. Given the rule's requirements and the penalties for noncompliance, health care providers are advised to contact an attorney to assist with Red Flags Rule compliance requirements by the May 1, 2009 deadline.

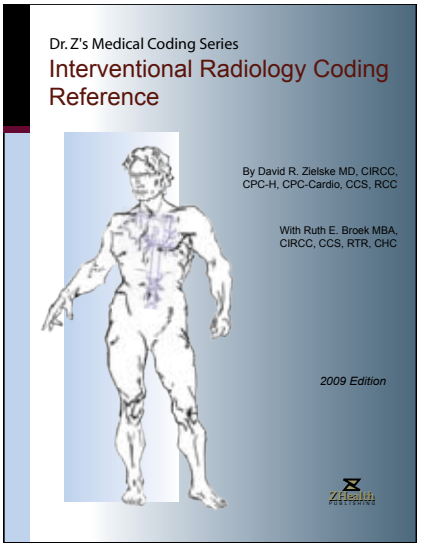
David Anthony is a partner in the Consumer Law and Complex Litigation Practice Groups of Troutman Sanders LLP. He regularly represents businesses in consumer and commercial litigation and compliance issues. (david.anthony@troutmansanders.com)

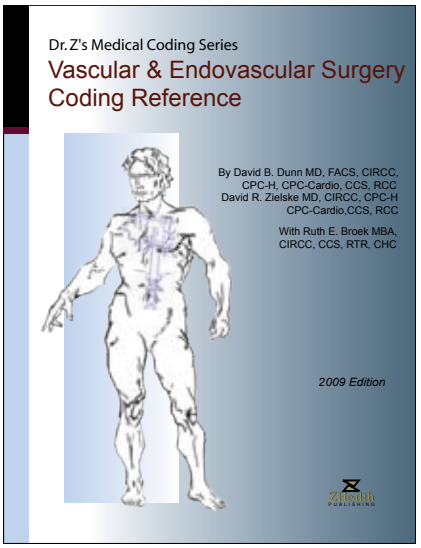
Erin S. Whaley is an associate with Troutman Sanders LLP, where she has practiced since 2004. She practices health care law and advises health care providers on a broad range of issues, including regulatory compliance. (erin.whaley@troutmansanders.com)

Paige S. Fitzgerald has been an associate with Troutman Sanders LLP since 2004. She is a member of the consumer law and health care practice groups, and regularly counsels clients in numerous regulatory compliance areas. Before joining Troutman Sanders, Paige served as an assistant attorney general at the Virginia Attorney General's office and was counsel to Virginia's Medicaid agency. (paige.fitzgerald@troutmansanders.com)

THE BOOKS







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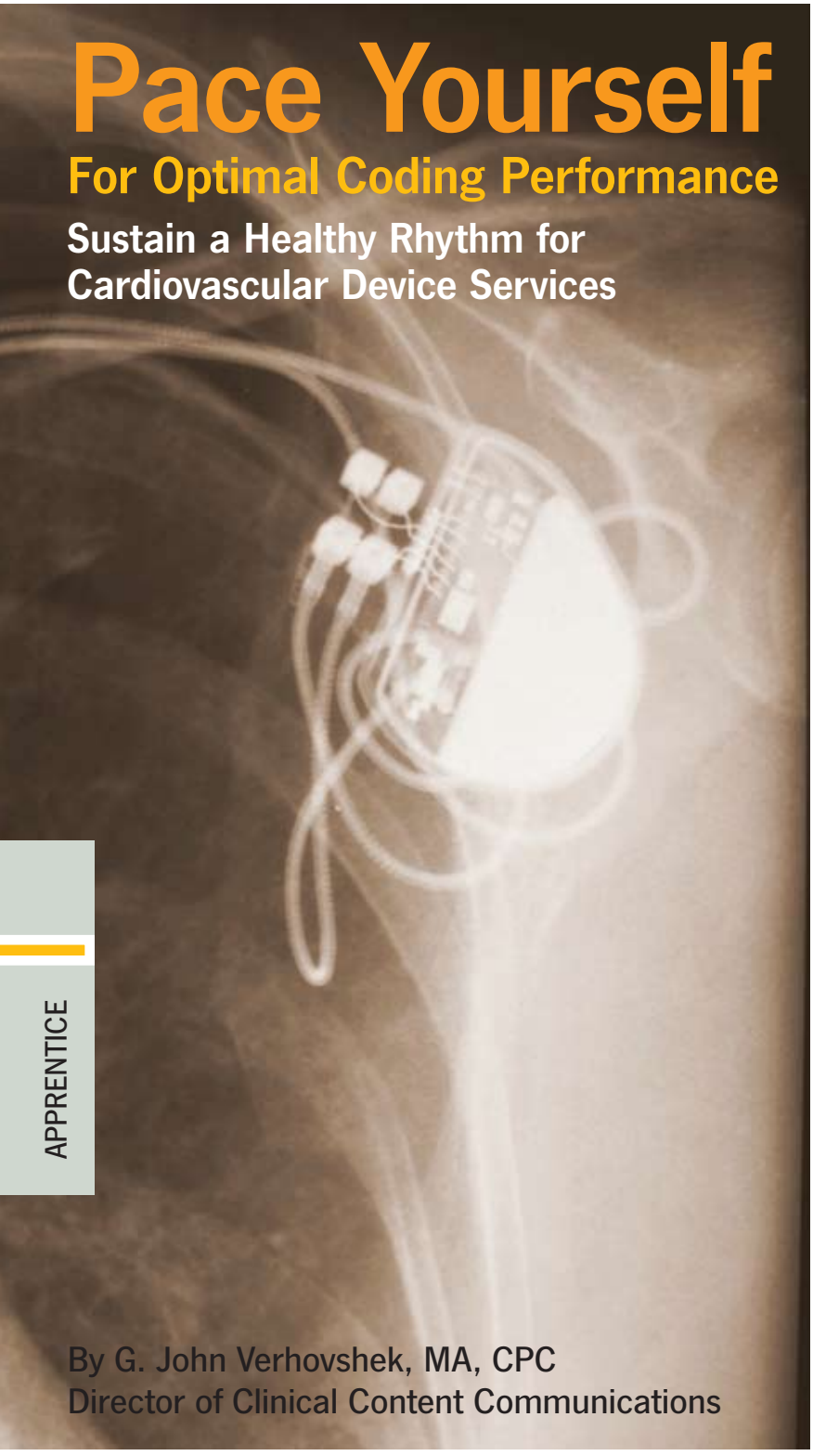

APPRENTICE

By G. John Verhovshek, MA, CPC
Director of Clinical Content Communications

In February, you're likely to turn your thoughts to matters of the heart. What a better time, then, to catch up on the latest changes in cardiac coding?

CPT® 2009 introduces significant revisions to cardiovascular medicine codes, including all-new codes for pacemakers, cardioverter-defibrillators, and other cardiovascular devices. To make way for these changes, the American Medical Association (AMA) eliminated codes 93727-93736 and 93741-93744, which previously reported many of these services.

Pacemakers

A cardiac pacemaker implanted in the chest delivers electrical impulses to pace the beats within a patient's heart. The pacemaker may have one, two, or more leads delivering the electricity to regulate the heart's movements. A pacemaker with pacing and sensing functions in a single chamber of the heart will have one lead, for instance, whereas a pacemaker with pacing and sensing functions in three chambers of the heart will have three leads.

To report the initial pacemaker evaluation and programming, both before and immediately after implantation, you will now call on 93286 *Peri-procedural device evaluation and programming of device system parameters before or after a surgery, procedure, or test with physician analysis, review and report; single, dual, or multiple lead pacemaker system* for reimbursement. CPT® guidelines clarify that you may report one unit of 93286 for a pre-procedure evaluation, and a second unit of 93286 for the first post-procedure evaluation. You should not report 93286 in addition to other pacemaker evaluation services, as described below.

Periodically, the physician must test a pacemaker, and possibly re-adjust it for optimal performance. Evaluations fall into four categories: transtelephonic rhythm strip evaluation, face-to-face interrogation device evaluation, remote interrogation device evaluation, and programming device evaluation.

Transtelephonic rhythm strip evaluations allow physicians to check a patient's rhythm status remotely, and to verify the pacemaker is functioning well. Using a special transmitter, an impulse is sent via telephone and recorded at the physician's site. New code 93293 *Transtelephonic rhythm strip pacemaker evaluation(s) single, dual, or multiple lead pacemaker system, includes recording with and without magnet application with physician analysis, review and report(s), up to 90 days* describes the physician evaluation with analysis and report for evaluation of up to 90 days of stored data.

A similar remote service, 93294 *Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system with interim physician analysis, review(s) and report(s)*, describes the physician's work of downloading and evaluating up to 90 days of information stored within the pacemaker device, including programmed parameters, lead(s), battery status, capture and sensing function, and heart rhythm. A second code, 93296 *Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead pacemaker system or implantable cardioverter-defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results*, accompanies 93294 to report the technical portions of the service, including data acquisition and dissemination, receipt of transmissions, and technical review and support.

The physician also may provide an interrogation device evaluation face-to-face with the patient, as described by 93288 *Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead pacemaker system*.

A programming device evaluation includes all interrogation device evaluation components as described by 93288 or 93294, and further includes the selection of patient-specific programmed parameters. The appropriate CPT® code to describe this service depends on the number of leads in the pacemaker system:

93279 Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; single lead pacemaker system

93280 dual lead pacemaker system

93281 multiple lead pacemaker system

The AMA's *CPT® 2009 Professional Edition* (p. 410) lists the components that may be included in a programming device evaluation as described by 93279-93281.

Cardioverter Defibrillators

An implantable cardioverter defibrillator is therapeutic for patients with recurrent and sustained ventricular tachycardia or fibrillation. These devices can work like pacemakers, or can intervene when the cardiac rhythm is irregular, delivering stronger shocks as needed. They may have one, two, or multiple leads, depending on the patient's clinical condition.

Like a pacemaker, a cardioverter-defibrillator requires initial and subsequent programming, as well as periodic evaluation. For an evaluation and programming either before and/or immediately after surgery, a procedure, or test, select 93287 *Peri-procedural device evaluation and programming of device system parameters before or after a surgery, procedure, or test with physician analysis, review and report; single, dual, or multiple lead implantable cardioverter-defibrillator system*.

For a cardioverter-defibrillator's in-person interrogation device evaluation , select 93289 *Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; single, dual, or multiple lead implantable cardioverter-defibrillator system, including analysis of heart rhythm derived data elements*.

For a remote interrogation device evaluation, report 93295 *Interrogation device evaluation(s) (remote), up to 90 days; single, dual, or multiple lead implantable cardioverter-defibrillator system with interim physician analysis, review(s) and report(s)* for the physician portion of the service, with 93296 to describe receipt of transmissions, technical review and support, and data dissemination.

A cardioverter-defibrillator interrogation device evaluation, whether in-person or remote, requires examination of programmed parameters, lead(s), battery, capture and sensing function, presence or absence of therapy for ventricular tachyarrhythmias and underlying heart rhythm.

You should select a code for more-extensive programming device evaluation, which can also include sensor rate response, lower and upper heart rates, and atrioventricular (AV) intervals, among other components, according to the number of leads in the cardioverter-defibrillator system.

93282 Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; single lead implantable cardioverter-defibrillator system

93283 dual lead implantable cardioverter-defibrillator system

93284 multiple lead implantable cardioverter-defibrillator system

If the physician provides programming device evaluation of an implantable loop recorder system, which includes all the components of interrogation device evaluation, plus possible adjustment of tachycardia and bradycardia detection criteria, you should claim 93285.

Implantable loop devices

Implantable loop devices (ILDs) are useful in diagnosing the cause of syncope recurrent palpitations, or seizures in patients. Syncope can be caused by life-threatening arrhythmias. Devices such as Medtronic's Reveal® Plus are designed to record electrocardiograms (EKGs) as cardiac events are experienced by the patient. This helps physicians establish a definitive diagnosis. These devices require periodic evaluation and testing, which can include remote or in-person services.

For face-to-face interrogation device evaluation, including programmed parameters, and the heart rate and rhythm during recorded episodes, you should select 93291 *Interrogation device evaluation(s), (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; implantable loop recorder system, including heart rhythm derived data analysis).*

To report remote interrogation device evaluation, claim 93298 *Interrogation device evaluation(s), (remote) up to 30 days; implantable loop recorder system, including analysis of recorded heart rhythm data, physician analysis, review(s) and report(s)* for the physician portion on the service. Code 93299 *Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system or implantable loop recorder system, remove data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results* describes the technical portion of the service, including transmission receipt and technician review. You should not report a remote service more than once per 30 days.

If the physician instead provides programming device evaluation of an implantable loop recorder system, which includes all the components of interrogation device evaluation, plus possible adjustment of tachycardia and bradycardia detection criteria, you should claim 93285 *Programming device evaluation with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with physician analysis, review and report; implantable loop recorder system.*

Wearable Defibrillators

A wearable defibrillator, for example the LifeVest® from ZOLL LifeCor, is worn outside the body rather than being implanted. It includes an electrode belt and a monitor. It records and treats arrhythmic conditions in the patient and provides continuous EKG monitoring.

Physicians evaluate a wearable defibrillator in person, by interrogation device, as reported with 93292 *Interrogation device evaluation {in person} with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; wearable defibrillator system).* Note that you should report the initial setup for a wearable defibrillator using 93745 *Initial set-up and programming by a physician of wearable cardioverter-defibrillator includes initial programming of system, establishing baseline electronic ECG, transmission of data to data repository, patient instruction in wearing system and patient reporting of problems or events*. Do not report 93292 and 93745 simultaneously.

Cardiovascular Monitoring Systems

Although implanted, a cardiovascular monitor system does not have pacing or defibrillator functions. Rather, it detects and records heart data only. You should report 99290 *Interrogation device evaluation (in person) with physician analysis, review and report, includes connection, recording and disconnection per patient encounter; implantable cardiovascular monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors* when a physician meets with a patient face-to-face to download and evaluate the information stored within an implantable cardiovascular monitor system device, including battery status and all recordings of heart activities.

For remote physician interrogation of a cardiovascular monitor system, look to 93297 *Interrogation device evaluation(s), (remote) up to 30 days; implantable cardiovascular monitor system, including analysis of 1 or more recorded physiologic cardiovascular data elements from all internal and external sensors, physician analysis, review(s) and report(s).* You may report the technical portion of this service (transmission receipt, technician review, etc.) separately, when provided, using 93299. CPT® guidelines prohibit you from reporting a remote interrogation for an implantable cardiovascular monitor system more frequently than once every 30 days.

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Ambulatory Event Monitors

Like a Holter monitor, ambulatory event monitors (AEMs) are noninvasive devices used to diagnose or identify heart arrhythmias by recording heart activity for later evaluation. AEMs record a "loop" of heart action, erasing past recordings so that the record is limited. They can also be trigged by events—for example, only recording when the heart rate exceeds a certain threshold or when the patient pushes a button.

CPT® 2009 introduces two new codes to describe AEM-related services:

93228 Wearable mobile cardiovascular telemetry with electrocardiographic recording, concurrent computerized real time data analysis and greater than 24 hours of accessible ECG data storage (retrievable with query) with ECG triggered and patient selected events transmitted to a remote attended surveillance center for up to 30 days; physician review and interpretation with report

93229 technical support for connection and patient instructions for use, attended surveillance, analysis and physician prescribed transmission of daily and emergent data reports

These codes report AEM with real-time data analysis and transmission, called mobile outpatient cardiac telemetry. Examples of these devices are the CardioNet and the HEARTlink II™ monitoring devices. Code 93228 describes the physician's interpretation and review of the AEM report, while 93229 includes the technical support required for the AEM report's creation and transmission.

Descriptors for AEM codes 93224-93227 and 93230-93727 include modified language to accommodate new codes 93228 and 93229, and to clarify use for the existing codes. CE

[G. John Verhovshek, MA, CPC, is AAPC's director of clinical coding communications.]

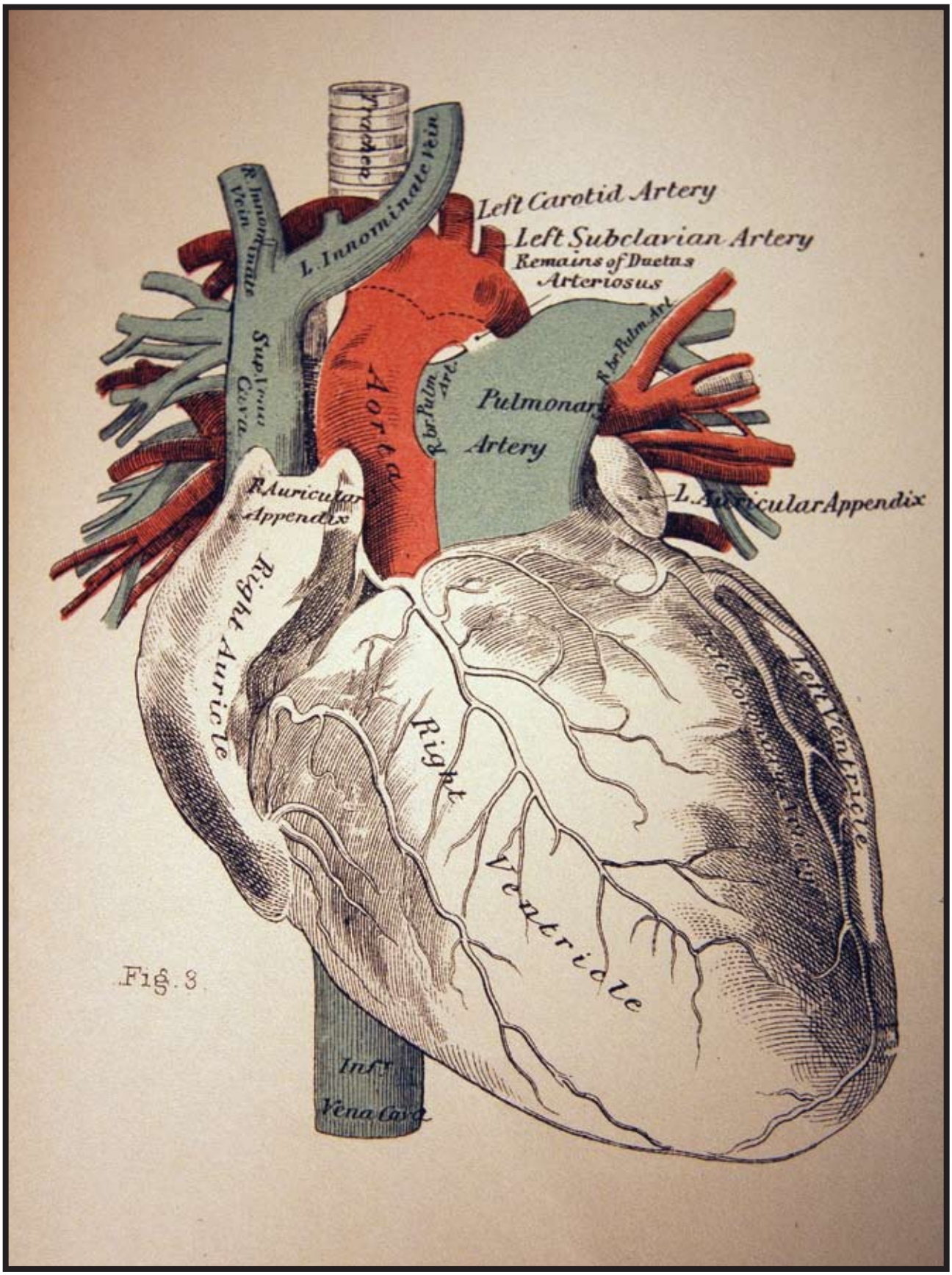
Trachea
R. Innominate Vein
L. Innominate Vein
Left Carotid Artery
Left Subclavian Artery
Remains of Ductus Arteriosus
Sup. Vena Cava
Aorta
R. br. Pulm. Art.
L. br. Pulm. Art.
Pulmonary Artery
R. Auricular Appendix
L. Auricular Appendix
Right Auricle
Right Ventricle
Left Ventricle
Inf. Vena Cava

Fig. 3

Don't Miss a Beat

When Coding Coronary Arterial Procedures

By David Zielske, MD, CPC-H, CIRCC, CCC, CCS, RCC

From a coder's perspective, the heart is made up of chambers, valves, and coronary and pulmonary arteries and veins. Let's focus on outpatient hospital and physician CPT® coding for diagnostic and interventional coronary arterial procedures.

Branch Out Coronary Artery Coding Know-how

Anatomically there are two coronary arteries, the right coronary (RC) and the left main coronary arteries. The left main quickly bifurcates into the left circumflex (LC) and the left anterior descending (LAD) coronary arteries. A common anatomic variant is trifurcation of the left main, with a ramus intermedius artery situated between the LAD and the LC. Branches of the LAD include several diagonal and septal perforator arteries. Branches of the LC include several marginal and, occasionally (five percent of patients), the posterior descending arteries (PDA) and branches of the RC include the acute marginal and the PDA (95 percent of patients). Branch vessel knowledge is imperative when coding coronary arterial intervention as CPT® coding considers all interventions performed within the main vessel (as defined by the coronary arterial vascular distribution modifiers LC, LD, and RC) and all of its branches to be a single vessel intervention.

Diagnostic coronary angiography (93508) describes a procedure involving selective injection and imaging of coronary arteries. CPT® codes 93539, 93540, 93541, 93544, and 93545 represent injection procedures for arterial conduits, saphenous vein bypass grafts (SVBPG), pulmonary arteries, the aortic root, and native coronary arteries. Each of these injection procedure codes are billed only once per patient encounter, regardless of how many individual vessels in each group are injected. This rule applies to all cardiac and coronary injection and imaging codes, 93539-93556.

Code 93539 *Injection procedure during cardiac catheterization; for selective opacification of arterial conduits (eg, internal mammary), whether native or used for bypass* is unusual as it is billed for selective arterial graft injection or when an artery (such as the internal mammary artery) is injected prior to coronary artery bypass graft surgery (CABG) to evaluate the vessel as a potential bypass graft. This imaging includes imaging of the proximal subclavian artery. Usually, code 93544 *Injection procedure during cardiac catheterization; for aortography* is performed as a necessity for aortic valvular disease or aortic aneurysm evaluation; however, it may be injected to evaluate the origins of SVBPG's when they are difficult to cannulate due to occlusions. When the aortic injection shows a patent graft, and then it is selected and injected (93540), the aortic root injection is not billed as it is considered a guiding shot to localize the graft's origin. If there is an additional separate medical necessity such as aortic valve regurgitation, then code 93544 can be billed for this indication. Codes 93539, 93540, and 93545 require selective catheter placement while the aorta (93544) is a non-selective vessel. The pulmonary arteries can be injected non-selectively from the right ventricle (RV) or main pulmonary artery (MPA), or selectively in a branch vessel.

Report Imaging S&I Separately

The injection imaging's supervision and interpretation (S&I) is reported separately. Arterial imaging code 93556 *Imaging supervision, interpretation and report for injection procedure(s) during cardiac catheterization; pulmonary angiography, aortography, and/or selective coronary angiography including venous bypass grafts and arterial conduits (whether native or used in bypass)* is billed once regardless of how many arteries are injected per patient encounter. This rule also applies to heart chamber injection and imaging codes 93542, 93543, and 93555. When diagnostic angiography is performed at the same setting as a coronary arterial intervention, append modifier 59 *Distinct procedural service* to codes 93555 and 93556 to alert Medicare the imaging procedures were part of a diagnostic exam (which led to the intervention procedure) and not just the intervention's guiding or follow-up image.

Know Intervention's Hierarchy Rules

Coronary arterial interventions include thrombolysis, thrombectomy, brachytherapy, angioplasty, atherectomy, and stent placement. The coronary interventional CPT® coding rules are well defined, are consistent across payers, and unchanged for the past 15 years. There is an established hierarchy for catheter based coronary arterial interventions:

- Stent placement supersedes atherectomy
- which supersedes angioplasty.

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When performing multiple interventions (defined as interventions in the LC, LAD, and/or RC), coding guidelines mandate billing the highest level of intervention as an initial vessel intervention.

For Medicare hospital billing, drug-eluting stent (DES) placement supersedes stent placement. This rule applies to each separate coronary arterial distribution as defined earlier. For all angioplasty, atherectomy, and stent placement procedures performed in a single coronary vascular distribution (LAD, LC, or RC), you are allowed a single interventional procedure code. For example, if stents are placed in two diagonals, a septal perforator and the LAD itself, only one stent placement code is allowed. Since intervention in the left main is considered part of any distal vessel intervention, only one stent is billed for all five stents placed even if a left main stent was also placed.

When performing multiple interventions (defined as interventions in the LC, LAD, and/or RC), coding guidelines mandate billing the highest level of intervention as an initial vessel intervention. Any other vessel interventions are again coded to the highest level of intervention but as an additional vessel intervention. You should never see two initial vessel coronary arterial interventional codes used during a single patient encounter.

Apply Bundling and Add-on Codes Rules

Certain coronary arterial interventions, such as rotational atherectomy, frequently lead to severe bradycardia. Temporary pacemaker use during coronary intervention is bundled in the procedure and is not separately billable. Some procedures, particularly SVBPG interventions, utilize a distal embolic protection device to capture embolic material. A few payers allow unlisted code 93799 to describe this while others bundle this into the primary interventional procedure. Catheter directed coronary arterial thrombolysis (drug infusion of a thrombolytic agent to dissolve blood clot, code 92975, is rarely billed as a stand-alone code. If catheter directed thrombolysis is successfully performed and an underlying stenosis is identified, followed by balloon or stent intervention, the thrombolysis becomes bundled in the intervention and is not separately billable. Catheter directed thrombolysis can only be billed if it is performed as the only intervention in a vascular distribution.

Percutaneous coronary arterial thrombectomy (the removal of clot or thrombus, code 92973 *Percutaneous transluminal coronary thrombectomy (List separately in addition to code for primary procedure*), is an add-on code used with any subsequent intervention performed with a balloon, atherectomy device, or stent placement. Bill these additional interventional procedural codes per separate coronary arterial vascular distribution.

Coronary brachytherapy is the placement of a localized radiation therapy source- usually a catheter, across a recurrent stenosis- and coded with 92974 *Transcatheter placement of radiation delivery device for subsequent coronary intravascular brachytherapy (List separately in addition to code for primary procedure).* Because of the advent of DES placement due to the decline in recurrent stenoses within these stents, coronary brachytherapy is performed less frequently. When a diagnostic coronary angiogram indicates a hazy or indeterminate lesion, further evaluation with an intravascular ultrasound (IVUS) (codes 92978 *Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; initial vessel (List separately in addition to code for primary procedure)* and 92979 *Intravascular ultrasound (coronary vessel or graft) during diagnostic evaluation and/or therapeutic intervention including imaging supervision, interpretation and report; each additional vessel (List separately in addition to code for primary procedure)*) or intravascular Doppler also known as wave wire or FFR, (codes 93571 *Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel (List separately in addition to code for primary procedure)* and 93572 *Intravascular Doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; each additional vessel (List separately in addition to code for primary procedure)*) procedure may be necessary. Because the vascular distribution rules apply to IVUS and intravascular Doppler, only one code is used to describe IVUS performed in the LAD, the first diagonal and the left main coronary arteries. All four IVUS and intravascular Doppler codes are add-on procedure codes.

Coronary angioplasty involves using a balloon to dilate a stenosis (initial and additional vessel codes 92982 and 92984) and may be the only intervention performed in a vessel. If a higher level intervention is also performed, the angioplasty is bundled and not billed. If a cutting balloon containing little "razor blades" on the outside to cut the

Usually, code 93544 (Injection procedure during cardiac catheterization; for aortography) is performed as a necessity for aortic valvular disease or aortic aneurysm evaluation; however, it may be injected to evaluate SVBPG origins that are difficult to cannulate due to occlusions.

recurrent stenoses' intimal hyperplasia is used, balloon angioplasty (POBA) codes 92982 and 92984 are used.

Coronary atherectomy involves removal of atheromatous material from a coronary artery (codes 92995 *Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; single vessel* and 92996 *Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; each additional vessel (List separately in addition to code for primary procedure*) and may utilize photoablation technique (laser), rotational, side-cutting, or other extraction devices to remove plaque material. Stent placements within the coronary arteries use initial and additional vessel codes 92980 and 92981 for physician billing and for non-drug eluting stents placement for hospital billing. Hospitals may use initial and additional vessel HCPCS Level II codes G0290 *Transcatheter placement of a drug eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel* and G0291 *Transcatheter placement of a drug eluting intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; each additional vessel* when billing Medicare for drug eluting stents placement.

Expect Reviews With Modifier Usage

Code interventions performed within a graft with a modifier representing the vessel the graft is anastomosed to. If an intervention is also performed in the same vascular distribution but through the native vessel origin, both interventions may be billed only if the separate interventions were not approachable via one vessel origin. One intervention would be the initial vessel intervention, the next would be an additional vessel intervention, but both with the same vessel modifier (LC, LD, or RC). The additional intervention requires modifier 59 and you should expect a report review. Intervention within a ramus intermedius should receive the modifier LC or LD describes the vessel more closely. Usually when a ramus variant is present, the LC or LD is a smaller vessel. If intervention is performed in a ramus and the LD, call the ramus the LC. If an intervention is performed in a ramus and the LC, call the ramus the LD. If intervention is performed in all three vessels, code the ramus appended with 59-LC (or LD) and again, expect a review of the report. Left main intervention alone is coded as either LC or LD; however, remember that with distal LC or LD intervention, the left main is included in the distal LC or LD intervention.

Watch Out When Billing Infusion Agents

Watch out when billing procedures for intravenous coronary thrombolysis, (code 92977), and catheter directed infusion of non-thrombolytic agent, (code 37202 and 75896). Code 92977 describes a high dose bolus of thrombolytic agent's intravenous injection to dissolve coronary arterial thrombus. This is usually performed in the emergency room by a nurse for a patient with acute myocardial infarction. The use of bolus IV infusions has waned when the critical "door to balloon" time was shortened during patient's care. Don't use code 92977 when an anti-thrombotic agent is infused intravenously during coronary intervention. This drug infusion is meant to prevent clot formation in the immediate post-stent placement time frame. It is only billed by the hospital and only with a HCPCS Level II J-code for the infused drug. Code 37202 is intended for the long term catheter directed drug infusion, not for the drug's bolus injection during an intervention (such as nitroglycerin or Verapamil for localized arterial spasm treatment). This is inherent to the intervention. Code 37202 is rarely ever billed during cardiac procedures.

These guidelines are well established and universally accepted in the CPT® coding literature in regards to coronary diagnostic and interventional outpatient procedural coding. Due to peripheral procedures' expansion into the cardiac catheterization lab, hospitals and cardiologists should be careful to use coronary interventional codes for coronary arterial interventions and peripheral interventional codes for peripheral interventional procedures performed in the catheterization lab.

David Zielske, MD, CPC-H, CIRCC, CCC, CCS, RCC, retired from active interventional radiology practice in 2003 after practicing for 14 years at several hospitals in the Nashville, Tenn. area. His fellowship and residency were at Emory in Atlanta, Ga. His certificate of added qualifications in interventional radiology, was obtained in 1995 with recertification in 2005. He started ZHealth (a physician-based coding and auditing firm) in 2000 and ZHealth Publishing in 2003 (an educational company focused on training in interventional radiology, cardiology and vascular surgery coding). He is a member of the National Advisory Board.

Don't Let Hemorrhoid Codes Be a Pain

By Linda M. Farkas, MD

Get the information you need to code hemorrhoid procedures accurately.

Everyone blood vessels that lie at the junction of the rectum and anus. Straining during bowel movements due to diarrhea or constipation can cause these veins to swell and inflame. Decreased venous return to the heart, as with hypertension or pregnancy, can increase the risk of hemorrhoid disease. Hemorrhoids typically occur in the right posterior, right anterior, and left lateral positions. An accessory hemorrhoid is one found in an atypical location, such as right lateral.

Varicose hemorrhoids are rarely dangerous, and often resolve within a few days with minor or no treatment. Individuals who suffer significant bleeding or discomfort from prolapse, or who have persistent symptoms following conservative medical management, may require surgical intervention.

To code hemorrhoid procedures accurately, you need two pieces of information: the hemorrhoid type and the precise method of treatment. CPT® divides hemorrhoids at any position into three types: internal, external, and mixed.

Internal hemorrhoids originate above the dentate line. This is an actual, discernable line—also referred to as the pectinate line or anorectal junction—dividing the anal canal from the rectum. A hemorrhoid originating above the dentate line (that is, further inside the body) may protrude through the anus to be visible outside the body. Such a hemorrhoid is defined as a prolapsed internal hemorrhoid. Because the area above the dentate line lacks pain receptors, an internal hemorrhoid will cause discomfort only if it is strangulated or incarcerated at the anal opening.

External hemorrhoids originate below the dentate line (outside the body). When external hemorrhoids are acutely swollen or thrombosed, they are more painful than internal hemorrhoids because they are lined with sensitive skin. Physicians are more likely to use a local anesthetic when treating external hemorrhoids.

A *mixed hemorrhoid* occurs as a confluence of veins from above and below the dentate line merge into a single area of swelling. Hemorrhoids of this type involve prolapsed mucosal tissue, along with the surrounding anoderm (skin).

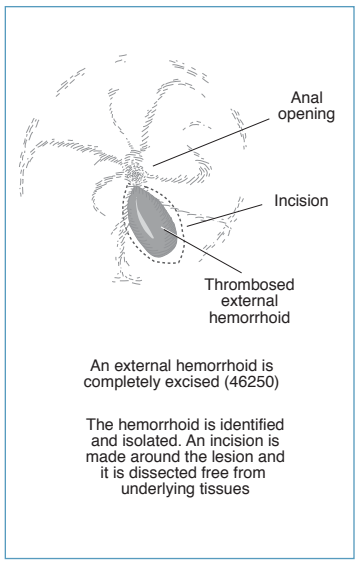
Physicians should document carefully the exact hemorrhoid type they treat. If the documentation is not clear, ask for additional details. You cannot select an appropriate hemorrhoid treatment code without this information.

Look to Ligation for Internal Treatments

Among treatments for internal hemorrhoids, the most common is simple ligature as described by 46221 *Hemorrhoidectomy, by simple ligature (eg, rubber band)*. Using an anoscope, the physician ligates (ties off) the hemorrhoid at its base, which eliminates the blood supply and causes the swollen vein to shrink over time. Eventually, the remaining tissue and band will slough off and exit with the stool. Only internal hemorrhoids are banded, and the procedure is performed in the office or less commonly in the operating room.

You should report 46221 only once per session, regardless of how many internal hemorrhoids the physician bands. That is, if the physician bands a single hemorrhoid, you would claim a single unit of 46221. If the physician bands three internal hemorrhoids, you would also report one unit of 46221.

Codes 46945 *Ligation of internal hemorrhoids; single procedure* and 46946 *Ligation of internal hemorrhoids; multiple procedures* also describe ligation of internal hemorrhoids over one or more sessions. Rather than ligature with a band, these procedures involve ligation of the hemorrhoid(s) with a suture. The surgeon will dictate ligation with a suture, such as a 2-0 polysorb or vicryl for instance. This procedure is most frequently performed in the operating room via an anoscope.



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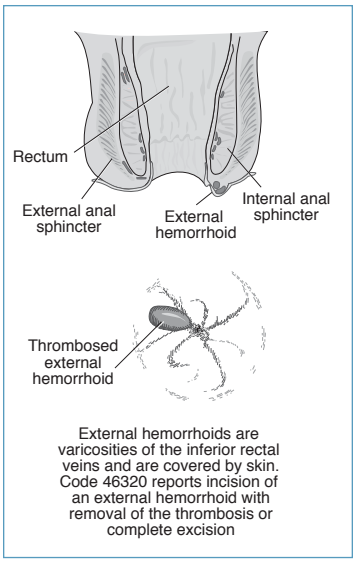

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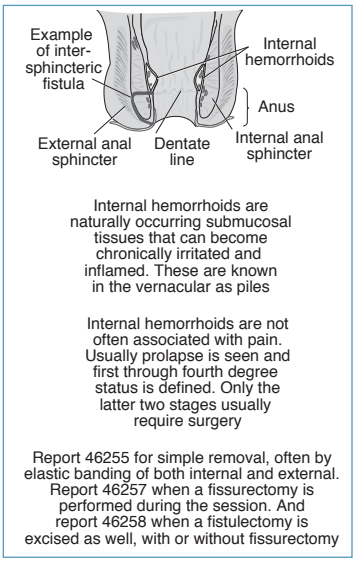


[Source: Ingenix]

Rather than ligature by banding or suture, physicians may choose to inject a sclerosing solution, such as sodium morrhuate, or 5 percent phenol in an oil mixture, into the rectal wall's submucosa under the internal hemorrhoid. As with ligature, this reduces blood flow and causes the hemorrhoid to shrink. You should code injection of sclerosing solution with 46500 *Injection of sclerosing solution, hemorrhoids*. You should claim no more than one unit of 46500 per session, regardless of how many injections or hemorrhoids the physician treats by injection.

CPT® 2009 also introduces a new code, 46930 *Destruction of internal hemorrhoid(s) by thermal energy (eg, infrared coagulation, cautery, radiofrequency)*, to describe thermal destruction of one or more hemorrhoids. This method involves burning away the inflamed hemorrhoid tissue using a special probe. Prior to 2009, you would have used now-deleted code 46934 to report this procedure.

For cryosurgery, or destruction of hemorrhoids by freezing, report unlisted procedure code 46999 *Unlisted procedure, anus*, according to CPT® instructions.

Hemorrhoidopexy Calls for Specific Code

Hemorrhoidopexy, also called procedure for prolapse and hemorrhoids (PPH) (or stapled hemorrhoidectomy), is an alternative surgical procedure to treat prolapsing internal hemorrhoids. The physician performs a progressive anal dilation with an obturator and inserts an anoscope to expose the rectal wall's circumference. Using a specialized stapling device inserted into the anus, the surgeon removes redundant tissue and staples the rectum's free mucosal ends together. The stapling device resembles an EEA stapler used for intestinal resections, but it does not remove a full thickness of circular tissue.

You should report hemorrhoidopexy using 46947 *Hemorrhoidopexy (eg, for prolapsing internal hemorrhoids) by stapling*. Limit your claim to a one unit of 46947 per session.

Medicare and other payers typically specify strict coverage requirements to justify reporting 46947. For instance, the physician may have to prove that other treatment methods were previously tried and failed, and Medicare specifically limits hemorrhoidopexy coverage to those prolapsed hemorrhoids of at least Grade III (that is, the hemorrhoid protrudes from the anus during a bowel movement, but can be pushed back into the anus). Check with your individual payer for its requirements prior to claiming 46947.

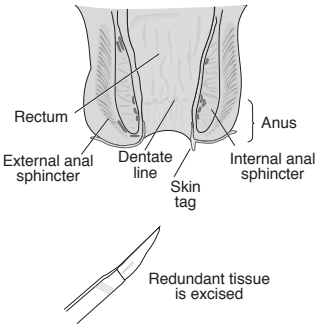
Thrombosis Affects Procedure Selection

Treatment options for external hemorrhoids vary depending on whether the hemorrhoid has become thrombosed, or clotted. As a rule, thrombosed external hemorrhoids are the most painful of all hemorrhoid types.

When treating a thrombosed external hemorrhoid, the physician has three options:

1. Perform an excision to simultaneously remove the clot and hemorrhoid. For this procedure, you would report one unit of 46320 *Enucleation or excision of external thrombotic hemorrhoid* for each hemorrhoid/clot the physician treats.
2. Perform an incision and drainage (I&D) to remove the clot only. Often, the hemorrhoid will resolve on its own after clot removal. For this service, you may claim one unit of 46083 *Incision of thrombosed hemorrhoid, external* for each I&D the physician performs.
3. The thrombosed external hemorrhoid could resolve into a skin tag, at which point the physician may remove it. Skin tags occur below the dentate line, and are usually seen on the outside of the anus. A papilla is very similar to a skin tag, but is located at the dentate line. To report excision of the skin tag,

CPT® 2009 eliminated 46935, which previously described removal of external hemorrhoids by any method not described elsewhere.



Hemorrhoidal tags are remnant skin tissues from previous thrombotic hemorrhoids. This redundant tissue is excised when it becomes inflamed or affects anal hygiene

Report 46230 for the excision of external hemorrhoid tags and/or multiple papillae

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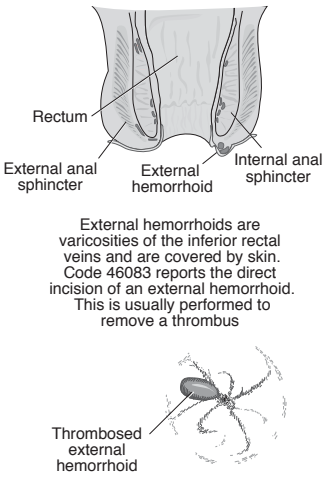

External hemorrhoids are varicosities of the inferior rectal veins and are covered by skin. Code 46083 reports the direct incision of an external hemorrhoid. This is usually performed to remove a thrombus

[Source: Ingenix]

code either 46220 *Papillectomy or excision of single tag, anus (separate procedure)* or 46230 *Excision of external hemorrhoid tags and/or multiple papillae*, depending on whether the physician removes a single tag or multiple tags.

If an external hemorrhoid is not thrombosed, the physician may remove it by excision, for which you may report 46250 *Hemorrhoidectomy, external, complete*. You would claim a single unit of 46250 per session, regardless of how many hemorrhoids the physician treats.

CPT® 2009 eliminated 46935, which previously described removal of external hemorrhoids by *any method* not described elsewhere. In the unusual case of external hemorrhoids removal by methods other than those covered above (for instance, cryosurgery or thermal energy), you now must report unlisted procedure code 46999.

Mixed Treatments May Include Associated Procedures

When coding for excision of mixed hemorrhoids, you must consider two additional factors:

- **Complexity.** Based on the number and size of hemorrhoids removed, the physician must make a subjective judgment whether to select 46255 *Hemorrhoidectomy, internal and external, simple* or 46260 *Hemorrhoidectomy, internal and external, complex or extensive*. As a general rule, single column removal describes a *simple* procedure, while removal of two or more columns may qualify as *complex*. When coding for a complex excision, physician documentation should include supporting information to justify the claim.

You should report a single unit of 42655 or 46260 per session, regardless of how many hemorrhoids the physician excises.

- **Same-Session Procedures.** The physician may perform other procedures, such as a fissurectomy, fistulectomy, or fistulotomy, at the same time as mixed hemorrhoids excision. Your coding must adapt to these circumstances.

An anal fissure is a tear in the anal tissue, which may accompany hemorrhoids and can cause severe pain and bleeding. Physicians may treat an anal fissure by excision in a procedure called a fissurectomy.

When a fissurectomy occurs with excision of mixed hemorrhoids, you should report either 46257 *Hemorrhoidectomy, internal and external, simple; with fissurectomy* or 46261 *Hemorrhoidectomy, internal and external, complex or extensive; with fissurectomy*, depending on the complexity of the hemorrhoid excision(s).

Occasionally, the physician may also perform fistulectomy to correct an anal fistula, which is an unnatural connection with an internal opening in the anal canal and an external opening in the skin near the anus. An anal fistula can form when an acute anal abscess that's drained (either on its own or via surgery) doesn't heal completely and becomes a chronic infection.

When fistulectomy occurs along with excision of mixed hemorrhoids, either with our without fissurectomy, you should select between codes 46258 *Hemorrhoidectomy, internal and external, simple; with fistulectomy, with or without fissurectomy* and 46262 *Hemorrhoidectomy, internal and external, complex or extensive; with fistulectomy, with or without fissurectomy*, as appropriate to the complexity of the hemorrhoid excision(s).

For treatment of mixed hemorrhoids by any method other than excision, you should report unlisted procedure code 46999. CPT® deleted destruction by any method internal and external code 46936.

Linda M. Farkas, MD, is a colorectal surgeon and teacher at the University of Pittsburgh Medical Center. She uses advanced laparoscopic skills including colectomy/procetectomy for cancer, transanal endoscopic microsurgery, robotic surgery, THD-Doppler guided hemorrhoidal ligation, and procedures for prolapsed hemorrhoids.

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Lots of New Code Picks
2009 HCPCS

By G. John Verhovshek, MA, CPC

PROFESSIONAL

HCPCS Level II codes have seen many hundreds of changes for 2009, but you'll find that the most substantial revisions affect durable medical and drug equipment supply codes.

New DME Codes

Among the most interesting additions to durable medical equipment (DME) codes are E0656 *Segmental pneumatic appliance for use with pneumatic compressor, trunk* and E0657 *Segmental pneumatic appliance for use with pneumatic compressor, chest*, which describe the Flexitouch® chest and trunk appliances. These devices, which are adjustable to the individual patient, supply pneumatic pressure to the trunk or chest to move excess fluid from a damaged lymph area into a healthy lymph area.

Another new code, E0770 *Functional electrical stimulator, transcutaneous stimulation of nerve and/or muscle groups, any type, complete system, not otherwise specified* now reports the WalkAide, a neural or smart prosthesis intended to address the lack of ankle dorsi-flexion in patients who have sustained damage to upper motor neurons or pathways to the spinal cord.

Codes E1356 *Oxygen accessory, battery pack/cartridge for portable concentrator, any type, replacement only, each* and E1357 *Oxygen accessory, battery charger for portable concentrator, any type, replacement only, each* pertain to the batteries that power portable oxygen concentrators (also known as oxygen generating portable equipment (OGPE)), available under the brand name Eclipse. Eclipse battery packs are similar to those used in laptop computers, and provide a power source to run the systems for several hours per charge.

Three new codes describe added accessories for a manual wheelchair. A standing feature in a wheelchair (E2230 *Manual wheelchair accessory, manual standing system*) allows its user to assume a standing position without transferring from the chair. Code E2231 *Manual wheelchair accessory, solid seat support base (replaces sling seat), includes any type mounting hardware* reports the supply when a firm seat replaces a flexible sling seat in a wheelchair. A dynamic seating frame, now reported with E2295 *Manual wheelchair accessory, for pediatric size wheelchair, dynamic seating frame*, allows coordinated movement of multiple positioning features. This, in turn, allows for greater range of motion and functional mobility in patients because it strengthens their muscles and joints.

HCPCS Level II 2009 also adds two new medical equipment codes describing spirometer, E0487 *Spirometer, electronic, includes all accessories* and A9284 *Spirometer, non-electronic, includes all accessories*. Code E0487 is redundant to existing code S8190 *Electronic spirometer (or microspirometer)* for an electronic device. You should not report S codes for Medicare, however, so E0487 is the correct code for Medicare claims. Consult with other payers to determine which code to use for supply of an electronic spirometer, and watch for a change in the status of S8190 in the future.

Added code K0672 *Addition to lower extremity orthosis, removable soft interface, all components, replacement only, each* describes any removable soft interface (the surface of the device in contact with the individual's skin) for a single knee brace replacement. Prior to 2009, no code reported these removable components properly, although L2820 or L2830 were often used for this purpose.

New Drug Codes

A number of new codes report drugs for which there previously was no code (usually because the drugs themselves are so new), as indicated in the chart below.

Code	Drug	Use	Trade Name
A9580	Sodium fluoride F-18	radiopharmaceutical	n/a
C9245	romiplostim	autoimmune disease	n/a
C9246	gadoxetate disodium	contrast agent	EOVIST
C9247	lobenguane	radiopharmaceutical	n/a
C9248	clevidipine butyrate	antihypertensive	Cleviprex
J0641	levoleucovorin calcium	osteosarcoma and methotrexate overdose	n/a
J1267	doripenem	antibiotic	DORIBAX
J1453	fosaprepitant (injected)	nausea treatment	EMEND
J1930	lanreotide	mitigate acromegaly	Samatuline Depot
J2785	regadenoson	raises heart rate	Lexiscan for stressed EKG
J8705	Topotecan (capsule or inject)	anti-cancer	Hycamtin

Other new codes include A6545 *Gradient compression wrap, non-elastic, below knee, 30-50 mm hg, each* for the supply of CircAid® Medical Products T-3 M™; L0113 *Cranial cervical orthosis, torticollis type, with or without joint, with or without soft interface material, prefabricated, includes fitting and adjustment* for a custom-made cranial cervical orthosis for patients with congenital torticollis, and; L8604 *Injectable bulking agent, dextranomer/hyaluronic acid copolymer implant, urinary tract, 1 ml, includes shipping and necessary supplies* to describe Deflux® injectable gel, a dextranomer/hyaluronic acid copolymer implant material used as a bulking agent in the treatment of vesicoureteral reflux (VUR).

New Procedure Codes

Three new procedure codes—G0398, G0399, and G0400—now describe home sleep studies. These codes are more precise than CPT® code 95086, which describes an unattended study, but does not describe specifically a home sleep study.

Another group of added procedure G codes (G0416-G0149) now apply for prostate saturation biopsy. This technique, performed under general anesthesia using a transrectal ultrasound probe to image the prostate, uses a grid or template to identify the precise location of each biopsy core.

For Medicare patients only, codes G0412-G0415 describe pelvic bone fracture care similar to that described by CPT® codes 27215-27218. Unlike the category I codes, however, the new HCPCS Level II codes apply to either unilateral or bilateral fractures.

A new temporary code, S2118 *Metal-on-metal total hip resurfacing, including acetabular and femoral components*, now applies for total hip resurfacing/arthroplasty. For those payers who accept S codes, you no longer have to report 27299 *Unlisted procedure, pelvis or hip joint* for this service. In contrast to total hip replacement/arthroplasty, total hip resurfacing/arthroplasty does not include femoral head and neck removal, or bone removal from the femur. Instead, an artificial shell is placed over the top of the femur, and another shell is inserted in the acetabulum (the cup-shaped cavity on the hip bone where the femur fits into). Several metal-on-metal systems, including the Birmingham Hip Resurfacing Device (BHR) and the Cormet Hip Resurfacing system, have garnered FDA approval. The Buechel-Pappas Integrated Total Hip Replacement, which includes a metal femoral component and a polyethylene acetabular component, has also been approved by the FDA. The Conserve® Plus device, another metal-on-metal system, is in the FDA approval process.

Deleted, Replaced by New HCPCS Level II Codes

Many new-for-2009 HCPCS Level II codes simply take the place of now-deleted codes. For example, codes L7611-L7622, which described terminal hook device prosthetics, were deleted and replaced directly with new codes L6711-

Deleted	Replacement	Drug	Trade Name
C9237	**J1930**	lanreotide acetate	Samatuline Depot
C9238	**J1953**	levetiracetam	Keppra
C9239	**J9330**	temsirolimus	Torisel
C9240	**J9207**	ixabepilone	Ixempra
C9241	**J1276**	doripenem	DORIBAX
C9242	**J1453**	fosaprepitant	EMEND
C9243	**J9033**	bendamustine HCl	Ribomustin and TREANDA
C9244	**J2785**	regadenoson	Lexiscan
J3100 (50 mg)	**J3101 (1 mg)**	tenecteplase	TNKase
J9182	**J9181**	etoposid	Eposin, Etopophos, Vepesid, and VP-16
Q4096	**J7186**	ristocetin cofactor	Alphanate
Q4097	**J1459**	immune globulin	Privigen
Q4098, J1751, J1752	**J1750**	iron dextran	DexFerrum and Infed
Q4099	**J7606**	Formoterol fumarate	Foradil

L6722. The codes were re-numbered to allow for consolidation and inclusion of terminal hook device supply codes into a single code category, L6703-L6810.

Skin substitute codes J7340-J7349 were deleted and replaced with new codes Q4100-Q4114. The language within the codes was simplified, so code choice can be made according to the brand of the item used as a skin substitute; for example, Q4103 *Skin substitute, Oasis burn matrix, per square centimeter.*

Codes reporting "Welcome to Medicare" services have also undergone revision. New code G0402 *Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment* replaces G0344 for an initial visit. The eligibility period for a new Medicare beneficiary to receive an initial preventive physician exam was extended to 12 months, up from the previous six months under G0344. Screening electrocardiogram during a "Welcome to Medicare" visit, previously reported with G0366-G0368, should now be reported with G0403-G0405, as appropriate to the specific service.

Several codes for drug reporting were upgraded from temporary status to full-fledged J codes. Two J codes were also replaced to report identical drugs, but with slight changes, as indicated in chart.

Codes J7602 and J7603 to report Albuterol, an inhalation solution administered for the treatment of asthma, have been replaced with four new codes, J7611-J7614, to accommodate changes the packaging and use of albertol and levalbuterol administered through DME.

Deleted, Replaced by CPT® Codes

A few HCPCS Level II codes were replaced with CPT® codes. The most prominent example may be the elimination of G0308-G0327, to describe end stage renal disease (ESRD)-related services, from HCPCS Level II. New CPT® codes 90951-90970 now describe the identical services.

G codes to describe insertion of single chamber cardioverter defibrillator pulse generator (G0297), and insertion of dual chamber cardioverter defibrillator pulse generator with insertion of repositioning of leads (G0300), are deleted this year. Hospitals should now bill CPT® codes 33240 *Insertion of single or dual chamber pacing cardioverter-defibrillator pulse generator* and 33249 *Insertion or repositioning of electrode lead(s) for single or dual chamber pacing cardioverter-defibrillator and insertion of pulse generator*, respectively, to report these procedures, along with the applicable device C codes, for payment under the Outpatient Prospective Payment System (OPPS).

Laparoscopic hernia repairs finally make the transition from HCPCS Level II to CPT®, as well, with the deletion of S2075-S2077. These codes are replaced with six CPT® codes: 49652 and 49653 for laparoscopic repair of ventral, umbilical, spigelian or epigastric hernia; 49654 and 49655 for initial incisional hernia repair, and; 49656 for recurrent incisional hernia repair. All laparoscopic hernia repairs 49652-49656 include mesh insertion, when required.

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For Medicare patients only, codes G0412-G0415 describe pelvic bone fracture care similar to that described by CPT® codes 27215-27218. Unlike the category I codes, however, the new HCPCS Level II codes apply to either unilateral or bilateral fractures.

Code S2135, for treatment of Morton's neuroma, has been deleted and replaced with two new CPT® codes: 64455 reports steroid injection for diagnostic or therapeutic services, while 64632 reports an alcohol dilute injection or another neurolytic agent to destroy the nerve.

S9092 was deleted for 2009 and replaced by CPT® code 95992 *Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day*. Canalith repositioning procedures (CRPs) are systematic and therapeutic positionings of the head designed to roll a calcium crystal within the semicircular canal's convolutions.

Deleted, Not Replaced

Some codes were deleted without replacement for 2009. For example, Roche Pharmaceuticals discontinued the sale and distribution of its anti-HIV medication HIVID® (zalcitabine) tablets as of Dec. 31, 2006. Code S0141, which previously described the drug, has been deleted. Similarly, S0143, which described Aztreonam lysine for inhalation, was eliminated pending further clinical study and FDA approval of the drug.

Descriptor Revisions

With few exceptions, revisions of HCPCS Level II code descriptors provide clarification on proper code use, rather than changing the code meaning. For instance, the term *sterile* was added to several dozen dressings supply code descriptors (such as A6010 *Collagen based wound filler, dry form, sterile, per gram of collagen*) to confirm that the codes are reserved for surgical-grade dressings and fillers. Likewise, *Injection* was added to many J code descriptors to clarify route of admission. In these, and most other cases in which existing code descriptors have undergone revision for 2009, proper code application remains the same as in previous years.

Several descriptor revisions deserve special attention. Descriptors for transthoracic echocardiography codes C8921-87928 now add the phrase "or without contrast followed by contrast" to specify that a failed "without contrast" echocardiography is bundled to a follow-up echocardiography with contrast. Plus, two new C codes, C8929 and C8930, now report transthoracic echocardiography with contrast, or without contrast followed by contrast, in the hospital setting.

The inclusion of "and/or vacuum" to the descriptor for L4360 *Walking boot, pneumatic and/or vacuum, with or without joints, with or without interface material, prefabricated, includes fitting and adjustment* now allows you to report this code for VACO®ped, a cast replacement system for the treatment of injuries of the lower leg and foot that can be used for the entire rehabilitation after ankle fractures and other injuries. The VACO®ped uses a self-adjusting vacuum cushion to conform to the patient's anatomy. Along with a rigid lattice frame, the vacuum cushion provides cast-like stabilization.

Also, the term *injection* was removed from the descriptor for S0088 *Imatinib, 100 mg* to clarify that the code may also apply for Gleevec (imatinib) tablets to treat Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML) in chronic phase; Philadelphia chromosome positive chronic myeloid leukemia (Ph+ CML) in blast crisis, accelerated phase, or in chronic phase after failure of interferon-alpha therapy; and some patients with Kit (CD117)-positive gastrointestinal stromal tumors (GIST).

Additional changes to HCPCS Level II 2009 include new temporary (non-Medicare) S codes for genetic testing and detection of rupture of fetal membranes, expanded telehealth services (consultations, G0406-G0406) and dozens of additional G codes for reporting Physician Quality Reporting Initiative (PQRI) (pay for performance) measures, among others.

G. John Verhovshek, MA, CPC, is AAPC's director of clinical coding communications.

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Almeda Sweitzer-Gorman, CPC Jetersville VA
Sonia R Watts, CPC Lexington VA
Angela M Stading, CPC Mechanicsville VA
Stacy Q Wallace, CPC Mechanicsville VA
Pam Anne Powers, CPC Middlebrook VA
Patricia Ann Barletta, CPC Midlothian VA
Laura Lynn Lane, CPC Midlothian VA
Jennifer Elizabeth Lussier, CPC Mt Solon VA
Cindy L Campbell, CPC New Markey VA
Freda F Byrne, CPC Pulaski VA
Suzanna Griffith Cuellar, CPC Richmond VA
Lovell D Davis, CPC Richmond VA
Cynthia Hodges, CPC Roanoke VA
Sharon Slayton, CPC Roanoke VA
Patti Paule-Carres, CPC Winchester VA
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Sherry Sandvig, CPC Richland WA
Kim Engel, CPC Shelton WA
Dawn R Madsen, CPC Spokane WA
Beth Ann Beals, CPC Clinton WI

Apprentices

Jadmeerhan Farole Biteng, CPC-A APO AE
Stanalee Ruth Blackburn, CPC-A APO AE
David Andrew Bull, CPC-A APO AE
Tami Lyn Mammenga, CPC-A APO AE
Gabriele Gisela Moore, CPC-A Apo AE
Mary F Greenleaf, CPC-A APO AE
Loretta Sinanovic, CPC-A Glendale AZ
Candice Dyxse Czelusniak, CPC-A Mesa AZ
Michelle Leigh Sedivy, CPC-A Phoenix AZ
Jessica Ann Armenta, CPC-A Tucson AZ
Jessica Yvonne Perez, CPC-A Tucson AZ
Maria Lourdes Quijano, CPC-A Burbank CA
Nicole Marie Moreno-Boyce, CPC-A Galt CA
Karin Lee Burkett, CPC-A Granite Bay CA
Queennie Jane R Piol, CPC-A Los Angeles CA
Michelle C Smallwood, CPC-A Moreno Valley CA
Margretta M Gilli, CPC-A Oceanside CA
Janice Scott, CPC-A Sacramento CA
LaShanda R Ward, CPC-A Sacramento CA
Sarah D Lopez-Nolasco, CPC-A San Diego CA
Betty Wong, CPC-A San Francisco CA
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Diana Terrazas, CPC-A Tuolumne CA
Joyce Ann Rice, CPC-A Vallejo CA
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Darlene Maranga, CPC-A Van Nuys CA
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Tereesa Aqleh, CPC-A West Covina CA
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Maria Joseph, CPC-A Bellerose NY
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Tammy M Macklin, CPC-A Buffalo NY
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Karen A DeSimone, CPC-A Clifton Park NY
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Anne Margaret Fargnoli, CPC-A Endicoti NY
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Jodi M Bond, CPC-A, CPC-H-A Kenmore NY
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Jessica Johnson, CPC-A Gresham OR
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Heather Elise Harris, CPC-A Portland OR
Cecilia Gilman, CPC-A Redmond OR
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Jil Amanda Anderson, CPC-A Eagleville PA
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Diane Lynn Saathoff, CPC-A Erie PA
Brian W Isaac, CPC-A King of Prussia PA
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Patricia A Conneen, CPC-H-A Newton Square PA
Julie Greene, CPC-A Oil City PA
Germaine Anderson, CPC-A Philadelphia PA
Nakeyia T Jenkins, CPC-A Philadelphia PA
Holly Kline, CPC-A Philadelphia PA
Leslie Kyler, CPC-A Philadelphia PA
Candace T. Pepenelli, CPC-A Philadelphia PA
Megan Lynn Reilly, CPC-A Philadelphia PA
Karen Rosanio, CPC-A Philadelphia PA
Tara Taws Claghorn, CPC-A State College PA
Sheena Shavorne Cumberbatch, CPC-A Kingstown Saint Vincent
Onika L Kydd, CPC-A Kingstown Saint Vincent
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Daleya Loomis, CPC-A West Jordan UT
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Andrea S Sears, CPC-A Chesterfield VA
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Kendall Fairburn, CPC-A Roanoke VA
Marilyn Badnock, CPC-A Kingstown, St Vincent VI
D LaDon Grubbs, CPC-A Issaquah WA
Mozel Bendshadler, CPC-A Seattle WA
Mandy Carr, CPC-A Spokane Valley WA
Amy Glen, CPC-A Tacoma WA
Steven B Cole, CPC-H-A Walla Walla WA

Specialties

Gail W Mitchum, CPC, CPC-GENSG Enterprise AL
Paul G Cadorette, CPC, CPC-H, CPC-P, CPC-ASC, CPC-ED, CPC-ORTHO Benton AR
Tammy Helton, CPC, CPC-E/M Farmington AR
Amy Kathleen Gibson, CPC, CPC-ED Tucson AZ
Michelle M Bernstein, CPC, CPC-PEDS Yuma AZ
Charlene Sippio, CPC, CPC-I, CPC-E/M Elk Grove CA
Virdell Cook, CPC, CPC-E/M Fairfield CA
Irene Castillo Leon, CPC, CPC-E/M Irvine CA
Maggie Mac, CPC, CPC-E/M Clearwater FL
Jean Acevedo, CPC, CPC-ENT Delray Beach FL
Maryann Palmeter, CPC, CPC-ENT Jacksonville FL
Kimberly Dale Perazzoli, CPC, CPC-I, CPC-E/M Lakeland FL
Candice M Ruffing, CPC, CPC-ENT Port Saint Lucie FL
Elena Miller, CPC, CPC-H, CPC-ED Riverview FL
Maria H Cunha, CPC, CPC-H, CPC-ED Thonotosassa FL
Erica Dawn Lee, CPC, CPC-P, CPC-E/M Gainesville GA
Sampuran K Khalsa, CPC, CPC-H, CPC-ANEST Kailua HI
Christina L Deeke, AAPC-ED Bloomingdale IL
Crisan K Houston, CPC, CPC-CARDIO, CPC-E/M Springfield IL
Chandra Lynn Stephenson, CPC, CPC-H, CPC-FP, CPC-INTMED, CPC-ORTHO Lebanon IN
Nancy K Vinci, CPC, CPC-E/M Baton Rouge LA
Linda J King, CPC, CPC-GENSG Rehoboth MA
Amy Hamilton, CPC, CPC-E/M Great Mills MD
Lynne E Fitzpatrick, CPC, CPC-GENSG, CPC-ORTHO Brewer MI
Syd Stevens, CPC, CPC-INTMED Kansas City MO
Charlene N Miller, CPC, CPC-GI Statesville NC
Tina Cressman, CPC, CPC-H, CPC-P, CPC-I, CPC-E/M Cherry Hill NJ
Heather D Gatton, CPC, CPC-H, CPC-P, CPC-FP Maple Shade NJ
Patricia M Kisiel-Neunder, CPC, CPC-E/M Elma NY
Jessica L Jeune, CPC, CPC-E/M Latham NY
Leesa A Israel, CPC, CPC-URO Macedon NY
Toi McCormick, CPC, CPC-E/M Akron OH
Johann Wasik, CPC, CPC-E/M, CPC-OBGYN Marysville OH
Melinda S Ritchey, CPC, CPC-E/M Massillon OH
Cassandra Endres, CPC, CPC-E/M Erie PA
Jean M Smith, CPC, CPC-E/M Scenery Hill PA
Pamela Henderson, CPC, CPC-ANEST Cumberland RI
Maria Grimmage, CPC, CPC-ED Rock Hill SC
Madelyn McAfee, CPC, CPC-CARDIO Andersonville TN
Olivia D Jones, CPC, CPC-H, CPC-INTMED Goodlettsville TN
Pauline Bell, CPC, CPC-ANEST, CPC-GENSG Abilene TX
JoAnn Sherman, CPC, CPC-FP Abilene TX
Lisa D Tieu, CPC, CPC-E/M, CPC-GI Pearland TX
Linda Kidd, CPC, CPC-ENT Salt Lake City UT
Scarlett A Shirey, CPC, CPC-ORTHO Grottoes VA
Nancy Ashwell, CPC, CPC-CARDIO, CPC-GI Martinsville VA
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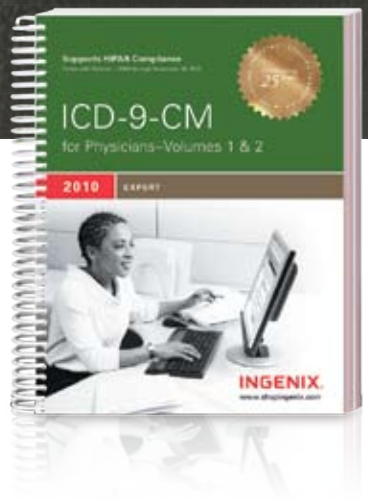

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Neonatal Care:

Out with the Old, In with the New

New neonatal care codes add beats to little hearts

By Kimberley Floyd Waldman, CPC, CPC-H, CCC, MCMC, CHA

Four million babies are born in the United States each year. Of these 4 million babies, 500,000 are born premature or less than 37 weeks old. Because premature births are so common, neonatal medicine is essential. The care provided in the first few fragile moments of life lays the foundation for a baby's health and gives hope to the parents for a positive future.

For proper usage of the neonatal CPT® codes, the baby must be 28 days of age or less with the date of birth counting as day one. Although neonatal intensive care services CPT® codes are new in 2009, the definition of critical care services remains the same. By CPT® 2009's definition, "a critical illness or injury" is defined as one that "acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient's condition."

In 2009, to report a critically ill neonate's initial inpatient neonatal critical care, 28 days of age or less, CPT® code 99468 *Initial inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or less* replaces 99295 *Initial inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or less*. Another addition for 2009 is CPT® Code 99472 *Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age for day three.*

This CPT® code would be used as the neonate passes from 28 days of age to 29 days of age and still remains in critical care.

The subsequent inpatient neonatal critical care, per day, for the evaluation and management (E/M) of a critically ill neonate also gets a new code this year with CPT® code 99469 *Subsequent inpatient neonatal crucial care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or less* replacing CPT® code 99296 *Subsequent inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or less.*

For example, a 27-day-old baby is admitted to the neonatal intensive care unit (NICU) and remains there through 29 days of age. The correct billing for this would be 99468 for the initial day, 99469 for day two, and 99472 *Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age* for day three.

Unlike adult critical care codes, neonatal critical care codes are not based on time spent rendering care to the patient. The NICU is not required as the place of service; however, if the critical care provided for a neonate is in the outpatient setting as in the emergency department (ED), critical care codes 99291 *Critical care, evaluation and management of the critically injured patient; first 30-74 minutes* and 99292 *Critical care, evaluation and management of the critically injured patient; each additional 30 minutes* would be the correct codes to report. When billing these charges, remember validation of neonatal critical care codes is not dependent on the provider's specialty (that is, neonatologist vs. cardiologist) performing the critical care. For proper CPT® code selection, factor the

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Although neonatal intensive care services CPT® codes are new in 2009, the definition of critical care services remains the same.

baby's age and verify that documentation warrants a critical care charge. For proper CPT® code selection, factor the baby's age and verify that documentation warrants a critical care charge. Contrary to critical care charges for patients over 24 months of age, neonatal critical care CPT® codes can only be reported by a single physician, once per day, and per patient in a given setting.

The intensive neonatal care codes, 99477 *Initial hospital care, per day, for the evaluation and management of the neonate, 28 days of age or less, who requires intensive observation, frequent interventions, and other intensive care services* continues to be used for initial hospital care per day for neonate's evaluation and management who requires intensive observation, frequent interventions, and other intensive care services. According to the 2009 CPT® book, "these services are for neonates who are not critically ill but continue to require intensive cardiac and respiratory monitoring, continuous and/or frequent vital sign monitoring, heat maintenance, enteral and/or parenteral nutritional adjustments, laboratory and oxygen monitoring, and constant observation by the health care team under direct physician supervision."

New for 2009 are three subsequent intensive care CPT® codes based on a low birth weight neonate or infant and current body weight. CPT® code 99478 *Subsequent intensive care, per day, for the evaluation nd management of the recovering very low birth weight infant (present body weight less than 1500 grams)* is for the subsequent intensive care, per day for the recovering very low birth weight infant (present body weight less than 1500 grams), 99479 *Subsequent intensive care, per day, for the evaluation dn management of the recovering low birth weight infant (present body weight of 1500-2000 grams)* is for the low birth weight infant (present body weight of 1500-2500 grams) and 99480 Subsequent intensive care, per day, for the evaluation and management of the recovering infant (present body weight of 2501-5000 grams is for the subsequent intensive care, per day, of the recovering infant weighing 2501-5000 grams.

For example, an infant weighs 1499 grams on days one through days four. On day five the infant weights 1500 grams. The billing for this would be 99478 x 5

(days one – four) and 99479 x1 (for day five),

For the sick neonate, less than 28 days of age but more than 5000 grams, who does not require intensive or critical care services, continue using subsequent hospital care codes 99231-99233.

Given the significant changes in neonatal coding for 2009, education of physicians, nurses, billing, and support staff are a necessary part of the transition as we continue to care for the littlest of us.

Kimberley Floyd-Waldman, CPC, CPC-H, CCC, MCMC, CHA, is a coding specialist at Nationwide Children's Hospital, Columbus, Ohio. She is a local chapter president and an instructor with American Institute of Healthcare Compliance and Healthcare Consulting Services-Society for Strategic Coders. She was featured in September's *Coding Edge* and serves on the 2009 Cardiology Specialty Exam board.

The Brain in the Ear

Coding can be easy, or coding can be hard. And sometimes, coding can be both easy and hard. Take the case of the Brain in the Ear:

Our adult patient presented with ear pain and loss of hearing. X-ray studies revealed a middle ear mass and it was thought the patient was suffering from an attic cholesteatoma. Surgery was scheduled.

The procedural coding is straightforward: the physician performed a mastoidectomy and tympanoplasty, but did not reconstruct the ossicular chain. The tympanic membrane was repaired. CPT® code 69641 does the job nicely.

Diagnostically, instead of a cholesteatoma, heterotopic glial tissue was found obstructing the epitympanic area of the middle ear. The note specifies there was no evidence of injury causing the ectopic brain tissue. We, of course, consult our ICD-9-CM Index. The entry, **Heterotropic**—see also **Malposition**, **congenital** may provide a clue. At **Malposition**, we find an entry for brain tissue, which takes us to 742.4 *Other specified anomalies of brain*. This code reports anomalies within the brain, but none of the inclusion terms in the tabular section address anomalies outside of the cranial cavity. You'd need a nod from your physician to report this as a congenital problem.

There may be another choice. Heterotopic glial tissue is often referred to in medical literature as glial choristoma. Choristoma is defined by *Dorland's Illustrated Medical Dictionary as "a mass of tissue histologically normal for an organ or part of the body other than the site at which it is located; called also … heterotopias and heterotopic tissue.*" This aligns well with the clinical picture of our operative and pathology reports. The ICD-9-CM provides very specific coding instruction on reporting choristoma: **Choristoma**—*see* Neoplasm, by site, benign. The site in this case is the middle ear, and the neoplasm table takes us to 212.0 *Benign neoplasm of nasal cavities, middle ear, and accessory sinuses*. A quick query to your doctor will ensure that you are correct in equating the heterotopia to choristoma.

Remember, you would also code the hearing loss, 389.05 *Conductive hearing loss, unilateral*.

If the coder is unable to contact the physician regarding the term choristoma, or the congenital nature of the defect, the only other choice would be 385.89 *Other disorder of middle ear and mastoid*.

Can You Code This Note?

The Case of the Sloughing Skin

Degloving during an accident often describes the traumatic avulsion of skin from the body or the controlled temporary removal of part of the face in plastic surgery or during a front cranial approach. In degloving, the skin often is disconnected from its blood supply. Sometimes the degloving is not so obvious, as in the case below.

Can *you* code this?

Indications: A 48-year-old complained of chronic pain in her right hip during walking and of decreased range of motion. She fell a year ago from a significant height, sustaining a fracture of the pelvic girdle and distal forearm and compressive vertebra fracture, developing hemorrhagic shock, and suffering multiple contusions of abdomen and thoracic wall. A closed degloving injury of the right thigh was initially missed. Several months ago, she detected a fluctuated lesion with mild progressive enlargement over time. The formation between subcutaneous tissue and deep fascia was propagated proximal from ischiolumbal to distal trochanteric and thigh region. On the distal part, the skin is thin because of the gravitation pressure of the lesion. The presence of a soft fluctuant area is the hallmark physical finding with decreased cutaneous sensation.

MRI revealed a fusiform formation with well-defined margins. The lesion was 26 cm long and its widest diameter was 9 cm. It appeared to be contained in the deep subcutaneous and perifascial space in the proximal part, generating a palpable bulge or compressive deformity on underlying muscles with mottled surface. It was thinning and herniating the skin at the level of proximal femoral region. When compared with skeletal muscle, the lesion was homogeneous without internal septa. A complete capsule was defined as a distinct hypointense peripheral ring visible in at least two imaging planes and conspicuous on MRI. Such findings closely correlate with seroma. This probably accounts for the long-standing nature of the lesion

Procedure: Surgical excision with complete resection of the seroma was performed. During the operation a palpable lump was resected and sent to pathology. The wound was closed with simple multilevel interrupted sutures.

Pathology reported a cystic cavity situated in the deep subcutaneous fat tissue with the wall made up of dense hypocellular fibrous tissue without recognizable epithelial lining and with reaction of giant cells in surrounding. The second specimen showed encapsulated fat necrosis with well-preserved outlines of nonnucleated adipocytes, totally or nearly totally surrounded by thin, fibrous tissue, with sporadic degenerative changes, including dystrophic calcifications).

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TOP 10
Ways to Find Money for Your Practice

10. **Verify eligibility and contact information.** It doesn't matter how well services are documented and coded if the claim comes back as undeliverable or unpaid. Verify every patient's information at each visit. Ensure there isn't a change in coverage and check contact data.

9. **Compare paid amounts to contracted amounts.** Payers have huge workloads. Don't assume the payers correctly reimburse services. Spot check payments regularly to verify contracted fees are followed.

8. **Track outstanding claims and follow up on misdirected or lost claims.** It's this simple: If you lose track of what you are owed, you risk losing what you are owed.

7. **Use more HCPCS Level II codes.** Injected medicines are listed in the J codes of the HCPCS Level II code books, and these codes are often overlooked by providers. An increasing number of payers pay HCPCS Level II codes.

6. **Check for secondary insurance.** Query the patient about potential secondary insurance to find another reliable source for payments.

5. **Compare what was billed to codes that were paid.** Some payers downcode an evaluation and management (E/M) service or make other changes to what was billed. Check your remittance advice and explanation of benefits (EOBs) against what was billed. If you don't agree, appeal the claim.

4. **Use modifiers appropriately.** Modifiers indicate a variance from the code's original intent. They can greatly reduce or enhance payment. Be sure you are using modifiers correctly. With multiple procedures, be sure to check RVUs and sequence the highest paying procedure first, using modifier 51 *Multiple procedures* on other multiples. This ensures you get the most money.

3. **Communicate in writing.** Keep a bank of templated letters for appeals and another for pre-authorizations. Use these letters regularly, and keep a record of what is effective.

2. **Get a second opinion.** Occasionally, coders should check each others' work to verify coworkers capture all charges. It's also a great idea to periodically shadow clinicians to ensure they document all their work. Learn from each other.

1. **Continue your education.** If you know the new rules, the new codes, and the new processes, your practice will prosper. Keep informed, and keep learning.

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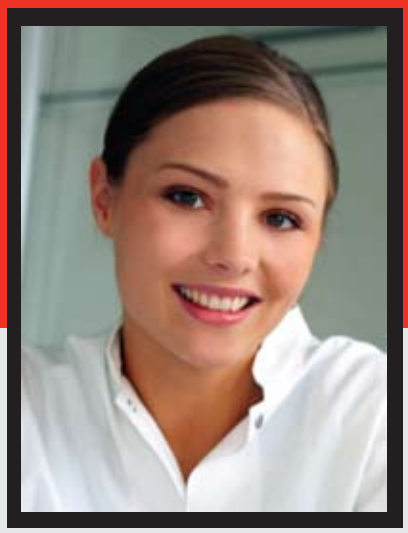

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These same questions can be accessed online at www.aapc.com/testyourself/. Once you go there and take the test, you can automatically grade your answers, correct any mistakes and have your CEUs automatically added to your *CEU Tracker* for submission.

1. Which codes are appropriate for critical care of a neonate (age 28 days or less) in the outpatient setting?
   a. 99468, 99469
   b. 99471, 99472
   c. 99475, 99476
   d. 99291, 99292
2. Which codes are appropriate to report subsequent care of a neonate (age 28 days or less) with a present body weight of more than 5000 grams who does not require critical or intensive care services?
   a. 99231-99233
   b. 99478-99480
   c. 99291-99292
   d. 99251-99255
3. For every claim you submit with PQRI data, you should:
   a. Wait for the Centers for Medicare & Medicaid Services (CMS) to report back to you
   b. Track whether CMS acknowledged the data and validated it toward your successful reporting percentage
   c. When possible, split the claim (that is, separated into smaller claims) prior to submission
   d. Account for the expected PQRI payments
4. The physician removes two internal hemorrhoids by rubber band ligature. In this case, the appropriate coding is:
   a. 46945
   b. 46946
   c. 46221
   d. 46221, 46221-59
5. An "accessory" hemorrhoid is:
   a. An internal hemorrhoid that becomes thrombosed
   b. A hemorrhoid not found in the typical right posterior, right anterior, or left lateral positions
   c. A hemorrhoid that lacks pain receptors
   d. A confluence of veins from above and below the dentate line that merge into a single area of swelling
6. The physician removes one large and two small bladder tumors via cystourethroscopy with fulguration. The appropriate coding under CPT®/AMA guidelines:
   a. 52240
   b. 52240, 52234
   c. 52240, 52234, 52234-59
   d. 52240, 52240-59, 55234
7. Which of these codes best describes a face-to-face, interrogation device evaluation of a multiple-lead pacemaker system, including physician review, analysis and report:
   a. 93281
   b. 93288
   c. 93294
   d. 93296
8. Which is the correct code to report supply of an electronic spirometer for a Medicare beneficiary?
   a. A9284
   b. E0487
   c. E0500
   d. S8190
9. Which supply code now describes the drug DORIBEX?
   a. C9241
   b. J0641
   c. J1267
   d. J1930
10. Which of the following have gained CPT® codes for 2009?
    a. Laparoscopic hernia repairs
    b. Administration of anti-HIV medication HIVID® (zalcitabine)
    c. Administration of Gleevec (imatinib) by injection or tablet
    d. "Welcome to Medicare" exam and associated screening electrocardiograms

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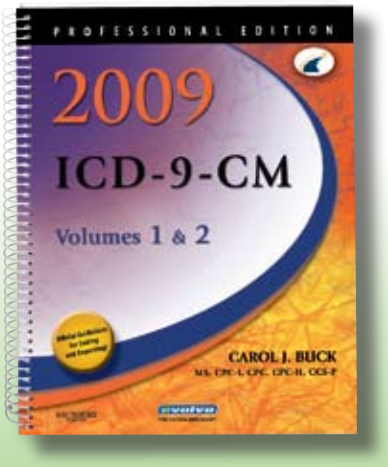

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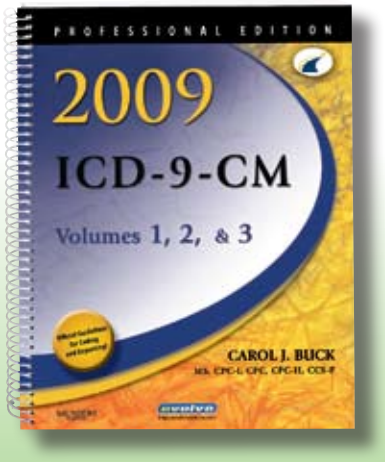

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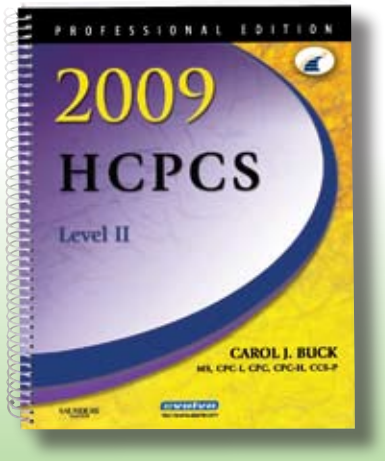

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