Assign G0269 for a percutaneous vascular surgery device used for vessel closure

Our hospital has received the U.S. Food and Drug Administration (FDA) approval for the Perclose percutaneous vascular surgery (PVS) device used for vessel closure following cardiac catheterization and percutaneous transluminal coronary angioplasty (PTCA). The vendor has instructed the coders to assign codes for suture of the artery for this procedure. However, we feel that this procedure represents closure of the operative site and, therefore, we should not report a code for it. What is the appropriate code assignment?

The PVS device is a minimally invasive suture-based surgical system used to close arterial access sites following diagnostic cardiac catheterization, therapeutic coronary angioplasty, and coronary artery stenting. Blood vessel suture with the Perclose device following catheterization or PTCA would be inherent to the procedure, so you should not assign an additional code for the suture.

The code that would be acceptable would be G0269 (Placement of occlusive device into either a venous or arterial access site, postsurgical or interventional procedure [e.g., angioseal plug, vascular plug]).

ED

Verify the payment policy for against medical advice or left without being seen ED visits

Can a hospital bill for an ED visit if the patient doesn’t see an ED physician and leaves the facility against medical advice?

Medicare does not seem to have a specific payment policy covering this question. However, if the ED provided services to a patient in triage, the visit had associated costs.

Leaving against medical advice generally occurs when a patient leaves before the completion of care, but after seeing the physician. Left without being seen usually refers to a patient who leaves before seeing a physician. This departure may occur before or after triage and before or after the ED staff places the patient in a room, but there is usually some nursing service provided.

Depending on what service the ED provided for the patient, it may be reasonable to submit a low-level charge.

Facilities handle this billing topic in different ways. The decision of whether to charge the patient...
ED — continued from p. 1

often depends on when (against medical advice or left without being seen) and why the patient left, what services the ED provided while the patient was there, and what the internal policy is for this type of occurrence. If the patient left after triage, and the ED provided no significant service, and especially if the patient had a long wait and left angry, an ED may elect not to charge for this visit. Some hospitals code and bill for triage-only visits to the level of service provided (usually level 1). Other facilities do not charge these visits, but code them with a pseudo-code for tracking purposes.

Sources that generally support reporting a low-level visit for triage only or left without being seen include the 2000 original final OPPS rule and the official Web site of the U.S. Department of Health and Human Services. Visit www.mass.gov/Eeohhs2/docs/dhcfp/g/regs/114_1_17.pdf for more information. (See p. 2 of this document for the definition of “Emergency Department visit” [triage only].)

I was unable to find anything on the CMS Web site that says you are not required to charge a triage-only visit, although some EDs have established this practice as an internal policy for public relations reasons.

In addition, there was a Trailblazer OPPS Teleconference on June 14, 2007, at which the following question was asked: Can a low-level visit be assigned for a triage-only ED visit when the patient elopes prior to any treatment?

The Trailblazer FI stated that you can assign a visit level. However, FIs have varying policies, so coders will need to check on payment policies in their area. The 2000 OPPS rule explicitly states that CMS bases facility charges on facility resource utilization. Thus, to the extent that your ED utilizes facility resources in the triage portion of an outpatient visit, the facility should report the resources used to accurately account for the service provided.

Each facility should develop a system for mapping the provided services or combination of services to the different levels of effort represented by the CPT codes.

As long as the facility documents the services furnished, the services are medically necessary, and the facility is consistently following its own system that reasonably relates the intensity of hospital resources to the different levels of HCPCS codes, assume that the facility is in compliance.

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For more information, see the April 7, 2000, Federal Register, p. 18451.

Additionally, on p. 18452, in response to a question about coding screening services, the publication states: “CMS will use the appropriate ED codes for screening services (as defined in the [Social Security Act] section 1867). If no treatment is furnished, we would expect screening to be billed with a low-level emergency department code. Section 1867 is the [Emergency Medical Treatment and Active Labor Act] rule discussing provision of a medical screening exam and transfers.”

Even if your ED decides not to charge for triage only, against medical advice, or left without being seen, it may be beneficial to assign a tracking code to reconcile the ED log, as well as for tracking ED statistics and performance.

Keep in mind that FI policies vary, so it is wise to verify the local payment policy with your FI.

E/M

Don’t use modifier to bypass mutually exclusive codes for professional, facility reporting

When it is appropriate to bill emergency E/M (99281–99285) and critical care codes (99291–99292) on a claim at the same time? With a status indicator of S, it would appear that critical care is distinct from the E/M codes.

According to the NCCI, you can consider the codes 99291–99292 and 99281–99285 mutually exclusive.

Injections/infusions

Report 90765 for first hour, 90766 for additional hours of IV infusion

We have a designated observation unit where we treat patients with IV infusion (i.e., therapeutic drugs) overnight. How would you code, for example, an infusion of therapeutic medication that starts at 11 p.m. and ends the following day at 11 a.m.? Does the daily initial service rule apply in this event?

Report CPT code descriptors for infusions in hours, not per day. The CPT manual states that you should...
**Injections/Infusions**  
< continued from p. 3

report only one “initial” service code, unless the unit establishes two IV sites.

In the scenario above, a therapeutic infusion ran for 12 hours over two calendar dates during one encounter or visit.

To report this service, use CPT code 90765 (IV infusion, for therapy/prophylaxis or diagnosis, up to one hour) for the first hour, and report 11 units of 90766 (each additional hour) for the remaining infusion time. If the patient was a scheduled infusion patient, make sure you do not bill observation hours, because payment under the OPPS includes the time allocated for the patient to be in a hospital bed. Only if the patient had a separate condition that the physician evaluated and/or treated, would observation hours be billable.

**Medicare**

**Be aware of primary vs. secondary diagnoses with ‘Welcome to Medicare’**

If a patient comes in for a mammogram and bone mineral density test (or any other preventive test) with an order from his or her physician with “Welcome to Medicare” as the diagnosis, how would you code this? I visited the CMS Web site, but wasn’t able to find anything.

In January 2005, the Medicare program expanded the number of preventive services available to Medicare beneficiaries as a result of Section 611 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

This expansion included coverage under Medicare Part B of a one-time initial preventive physical examination (IPPE), also referred to as the “Welcome to Medicare” physical exam for all Medicare beneficiaries whose Medicare Part B effective date began on or after January 1, 2005.

On January 1, 2007, Medicare further expanded the number of preventive benefits, as provided for in Section 5112 of the Deficit Reduction Act of 2005, to include coverage under Medicare Part B of a one-time preventive ultrasound screening for the early detection of abdominal aortic aneurysms (AAA) for at-risk beneficiaries as part of the IPPE. Both benefits, the IPPE and AAA, are subject to eligibility and other limitations. The IPPE is a preventive E/M service that includes the following seven components:

1. Review of an individual’s medical and social history with attention to modifiable risk factors
2. Review of an individual’s potential (risk factors) for depression
3. Review of the individual’s functional ability and level of safety
4. An examination to include an individual’s height,

Illustration by David Harbaugh

“Today’s special is for busy doctors. It’s a nourishing bouillabaisse administered by infusion or injection.”
weight, blood pressure measurement, and visual acuity screen

5. Performance and interpretation of an EKG

6. Education, counseling, and referral based on the results of the review and evaluation services described in the previous five elements

7. Education, counseling, and referral (including a brief written plan, such as a checklist, provided to the individual for obtaining the appropriate screenings and other preventive services that are covered as separate Medicare Part B benefits)

Based on the results identified upon completion of the seven elements above, the physician may refer the Medicare beneficiary for appropriate screenings and other preventive services that Medicare covers as separate Medicare Part B benefits.

It is important to understand that Medicare will cover additional screenings as part of the “Welcome to Medicare” exam provided that it considers the screenings a covered Medicare benefit and the referred screenings are clinically appropriate.

The term “clinically appropriate” refers to the screenings being medically necessary and meeting the indications and limitations of coverage that Medicare outlines in the respective Local Coverage Determinations (LCD) or National Coverage Determinations (NCD).

Medicare considers screening mammograms and bone mass measurements covered benefits for Medicare beneficiaries as long as the patient meets the LCD requirements.

In the instance of the screening mammogram, assign either diagnosis code V76.11 (Special screening mammogram for high-risk patients) or V76.12 (Special screening mammogram) as the primary diagnosis code on claims that contain only screening mammography services.

Or if the claim contains other services in addition to the screening mammography services, report diagnostic code V76.11 or V76.12 as a secondary diagnosis code.

You can see a list of the conditions that constitute high risk for ICD-9 diagnosis coding on p. 6 of CMS’ Change Request 3562, dated January 24, 2005, at www.cms.hhs.gov/Transmittals/Downloads/R426CP.pdf.

Be sure to include any of these pertinent conditions on the claim as a secondary diagnosis. The NCD for screening mammograms is very thorough, and you can use it as a reference when billing for the screening mammogram as part of the “Welcome to Medicare” exam. The NCD can be found at www.wpsic.com/medicare/part_b/policy/rad016.pdf.

As for the bone mass measurement, be sure to follow the guidelines as provided in your FI’s LCD. Bone mass measurement tests often lead to medical necessity denials related to not focusing on the indications and limitations of coverage as outlined in the coverage determination. Medicare will cover a bone mass measurement test when a physician performs the test on a qualified individual for the purpose of identifying bone mass, detecting bone loss, or determining bone quality. The term “qualified individual” means an individual who meets the medical indications for at least one of the five categories listed below:

1. A woman who has been determined by the physician, or a qualified nonphysician practitioner treating her, to be estrogen-deficient and at clinical risk for osteoporosis, based on her medical history and other findings

2. An individual with vertebral abnormalities as demonstrated by an x-ray to be indicative of...
osteoporosis, osteopenia (low bone mass), or vertebral fracture

3. An individual receiving (or expecting to receive) glucocorticoid (steroid) therapy equivalent to 5 mg of prednisone or greater per day for more than three months

4. An individual with primary hyperparathyroidism

5. An individual being monitored to assess the response to or efficacy of an FDA-approved osteoporosis drug therapy

Refer to your FI’s Web site for a copy of the FI’s LCD governing bone mass measurements. The LCD will highlight specific indications and limitations of coverage pertaining to performance of bone mass measurements in your state. Pay particular attention to the “Indications and Limitations of Coverage” section of the LCD.

The bottom line in billing for screening exams as part of the “Welcome to Medicare” exam is to follow the LCDs/NCDs governing each screening test. This will help you avoid any unnecessary medical denials by correctly assigning the appropriate ICD diagnosis codes or obtaining an Advance Beneficiary Notice when appropriate.

The above discussion about bone mass measurement comes from the United Government Services, which is now a part of the National Government Services Web site, as well as the FI for Wisconsin and other states.

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**Radiology**

**Report modifier -76 for repeat x-rays by the same physician, according to CPT Assistant**

I have a question regarding the use of modifier -76 for radiology procedures.

Consider the following scenario:

A patient comes into the ED with wrist pain. The physician orders a wrist x-ray with a minimum of three views. The x-ray shows that the patient...
has a fracture. The physician reduces the fracture and orders repeat x-rays with a minimum of three views again.

Under these circumstances, which modifier would be most appropriate: -76 or -59?

Modifier -76 is the most appropriate to use in this scenario.

According to CPT Assistant, September 2003, Volume 13, Issue 9, p. 3-1, “Coding Update: Hospital Outpatient Reporting Part IV: Use of the CPT Modifiers -52, -58, -59, -73, -74, -76, -77, and -76: Modifiers for Radiology Services: We frequently receive questions as to which modifiers are appropriate for radiology reporting purposes. According to the October 5, 2000, Program Memorandum, CMS recognizes the following modifier usage:

➢ Modifiers -50, -52 (Reduced Services), -59, -76, and -77, and the Level II modifiers apply to radiology services
➢ Modifier -52 (for indicating a terminated service based on the guidelines in transmittal 726) and -53, and the modifiers -73 and -74 do not apply to radiology services

The CPT Assistant referenced above is the most recent publication to address a situation similar to the scenario in question.

Surgery, maternity care and delivery

Use 59025-59 and 76819 when services are provided by two separate physicians during separate sessions

If a physician performs a nonstress test in the labor and delivery department, and then later in the day sends the patient down to the radiology department to get a biophysical profile ultrasound, do you code 76818 or do you code 59025-59 with 76819?

NCCI edits, Version 13.2, lists CPT code 59025 (Fetal nonstress test) as a component of the comprehensive code 76819 (Fetal biophysical profile; without nonstress test). The edits do allow for modification if the physician performs the component test (59025) during a separate session.

For the scenario you present, it would be appropriate to code 59025-59 (fetal nonstress) with code 76819 (fetal biophysical profile).

Two separate providers performed services during separate sessions; the obstetrician performed the fetal nonstress testing on the labor and delivery floor, and the radiologist performed the biophysical profile in the radiology department.

If the obstetrician or the radiologist had personally performed both tests on the same date of service, you would code only CPT code 76818 (Fetal biophysical profile; with nonstress test).

References
CPT Assistant, November 2004, p. 10.
Quick coding quiz

Try your hand at this coding quiz based on this month’s APC Answer Letter

Questions

Question 1: Which of the following codes would you use for placement of an occlusive device into either a venous or arterial access site, postsurgical or interventional procedure (e.g., angioseal plug, vascular plug)?
   a) G0260  
   b) G0268  
   c) G0269  
   d) G0270

Question 2: Which of the following ICD-9-CM codes would you use for a screening mammogram for a high-risk patient?
   a) V76.12  
   b) V76.11  
   c) V76.10  
   d) V76.19

Question 3: Which of the following CPT codes would you use for a fetal biophysical profile; with nonstress testing?
   a) 76827  
   b) 76820  
   c) 76819  
   d) 76818

Question 4: Which of the following CPT codes would you use for critical care, E/M of the critically ill or critically injured patient; each additional 30 minutes?
   a) 99293  
   b) 99292  
   c) 99291  
   d) 99294

Question 5: Which of the following modifiers does not apply to radiology services?
   a) -74  
   b) -50  
   c) -52  
   d) -76

Answers to the quiz can be found on the bottom of p. 7.