2011 CPT changes feature new time guidelines, subsequent observation care codes

Coders will have 212 new CPT® codes for 2011 as a result of the AMA’s CPT update. In addition, the AMA revised 106 codes and deleted 110 codes.

The AMA cleaned up CPT by eliminating overlapping or redundant codes, says Jennifer Avery, CCS, CPC-H, CPC, CPC-I, senior regulatory specialist for HCPro, Inc., in Danvers, MA. In addition, it removed some outdated codes because providers no longer perform those procedures. The AMA also created new combination codes to represent complete procedures, and eliminated component coding (reporting each part of a procedure) for certain sections, similar to the change to radiology coding for 2010.

Look for a large number of resequenced codes. The current codes remain the same, but the AMA has integrated new code concepts into the existing code families even when sequential code numbers are unavailable.

The AMA uses the “#” symbol to denote resequenced codes and parenthetical notes to indicate that codes are located in a different section.

Reporting time

In addition to changes to the actual codes, the AMA also revised the introduction of the 2011 CPT Manual. The AMA added a new subhead (Time) and guidelines for reporting time.

According to Avery, the AMA changed the instruction to:

➤ Create general rules for codes that do not specify their own time rules
➤ Define rules for services that start on one calendar date and continue on another
➤ Restate that time is counted as face to face unless otherwise specified

Time units are only reported once the midpoint has been passed. For example, at least 31 minutes must pass in order to report a code with a one-hour unit of time in its description. “That’s pretty consistent,” Avery says. “We’ve already been practicing that.”

When using time to select an E/M code, pick the code with the closest typical time, even if it is less than the actual time spent on the encounter. In order to report an E/M code based on time, make sure to follow the time rule in the E/M section. Specifically, the provider must spend more than 50% of the visit performing counseling and coordination of care.
New CPT
< continued from p. 1

If a physician spends 40 minutes with a new patient and more than 50% of the visit on coordination of care or counseling, report 99204. However, if the visit lasts for 35 minutes, report 99203.

Remember that you cannot count time twice. Look at the services where time is already factored in and make sure you don’t count that time twice by relying on it to report another code, Avery says.

Another time-related change involves services that span multiple days. For continuous services, coders should report all units on the date the service was started. For example, a patient comes into the ED at 11:30 p.m. and the physician starts an IV infusion. The infusion continues into the following day. Report all units of the service on the day the patient came in.

If the services are not continuous, the reporting changes. For example, a patient comes into the ED at 11 p.m. and receives an injection. At 1:30 a.m. the following day, the patient receives another injection. In this case, report two initial service codes on the appropriate dates. Do not use an add-on code for the second injection if it is provided on a different date of service, Avery says. An add-on code requires a base code on the same date and, in this case, the first injection code is on a different date of service.

This change generated a significant discussion during the AMA’s CPT® and RBRVS 2011 Annual Symposium held November 10–12, 2010, Avery says, so look for additional discussion or clarifications in the future.

E/M changes

The AMA added new codes for subsequent hospital observation (99224–99226). These codes match the subsequent hospital care codes already in use. The new codes are “per day” to report additional days of observation services; do not report them on the same day as the initial observation care or discharge services.

The new subsequent observation care codes are very similar to the subsequent hospital care codes for inpatients. They include similar time designations, but the AMA developed new typical patient and service descriptions.

All levels of subsequent observation care include review of the medical record, results of diagnostic studies, and changes in patient status (e.g., changes in history, physical condition, and response to management).

Multiple physicians (e.g., attending physician, surgeon) may report these codes for their E/M services provided to an observation patient. Do not report these codes on the same day as an office or ED visit, or on the same date as discharge from observation (code 99217).

Note that these subsequent observation care codes are resequenced. While the initial observation codes (99218–99220) remain the same, the AMA revised the guidelines for those codes to include references to the new subsequent observation care codes.

The CPT panel revised its guidance for critical care codes 99291 and 99292 to specifically state that, for hospital reporting purposes, critical care codes do not...
include the specified ancillary services, and facilities may report these services separately. The guidelines before the codes now identify services that are bundled when reporting professional services.

Be sure to read the revised guidelines for pediatric critical care transport codes 99466–99467. These codes report direct face-to-face care by a physician when a critically ill or injured pediatric patient 24 months of age or younger is transferred from one facility to another. Only report the face-to-face time, and do not assign codes 99466 and 99467 if the physician spent fewer than 30 minutes of face-to-face time with the patient during transport.

The AMA revised the list of bundled services for codes 99466 and 99467 to reflect the same services that were bundled in 2007. The guidelines also differentiate this list of services from those bundled into codes 99468–99472, 99475, 99476, and 99477–99480.

Also review the new coding tip on transfer of care under the Office and Other Outpatient Consultations section (codes 99241–99255). The tip defines what transfer of care is and when it takes place. Report services that constitute transfer of care with the appropriate code for a new or established patient office or other outpatient service, or a domiciliary, rest home, or home visit.

Radiology changes

The radiology changes for 2011 include five new codes, five revised codes, and eight deleted codes. New codes include 74176–74178, for CT of the abdomen and pelvis.

The AMA revised endovascular procedure codes 95954, 75960, 75962, and 75964 based on changes in the cardiology section. The AMA also deleted codes 75992–75996 for transluminal atherectomy supervision and interpretation.

Pathology and lab

The AMA established 16 new pathology and laboratory codes and revised seven others. Note that several of the codes in this section are resequenced.

Use new code 80104 to report qualitative drug screenings using a method other than chromatography for 2–15 drugs or drug classes. The AMA created this code to help clear up confusion over the 2010 CPT and HCPCS codes for reporting qualitative drug testing. Avery says. The code resolves prior difficulties reporting the multidrug screening kits that are now available.

You will also find new codes for influenza typing (87501–87503) and for molecular pathology testing for bladder cancer cells (88120–88121).

Medicine section

Use new codes 90460–90461 to report immunization administration of vaccine/toxoid component for pediatric patients through the age of 18. These two codes replace deleted codes 90465–90468. The immunization services that are part of these new codes include:

➤ Safe storage and inventory management
➤ Preadministration evaluation for contraindications or previous reactions
➤ Risk/benefit counseling
➤ Physical administration of the vaccine
➤ Documentation for each component administered
➤ Postoperative work for any reactions or side effects

New Category III codes

Look for 52 new Category III codes and 12 deletions, most of which have been converted to Category I codes.

The AMA added codes 0250T–0252T to identify bronchial valve procedures. Review the instructional notes for information on how to appropriately report these procedures. Review the new Category III codes for paravertebral facet joint injections with ultrasound guidance (0213T–0218T).

Look for new codes for acoustic cardiography (0223T–0225T). Use these codes to report the evaluation and optimization of physiologic data, including systolic and diastolic heart sounds and their relationships to the electrocardiogram. Do not report codes 93040–93042 with these new Category III codes. Also note that codes 0224T and 0225T include limited reprogramming of a cardiac pacing device.

When reviewing the 2011 CPT changes, be sure to check the AMA’s errata information, published on its website at http://tinyurl.com/npw5r2.
AMA changes cardiac cath, revascularization coding

New codes represent complete procedures, simplify coding decision-making

Some of the biggest changes to the CPT codes this year appear in the cardiac catheterization and revascularization codes.

In the past, coders would report up to three separate codes to describe an endovascular revascularization procedure—one code for the selective catheterization, one for the surgical component of the intervention, and one for the radiological supervision and interpretation of the procedure. Beginning in 2011, coders will only report one code to represent all of those services. (See the revascularization coding reference chart on pp. 6–7.)

As a result, the AMA deleted many of the transluminal angioplasty, open atherectomy, and percutaneous transluminal atherectomy codes. In their place is a new series of codes (37220–37235) to describe the complete procedures. You should report only one code from this group for each lower extremity vessel the physician treats.

“Those codes are meant to represent not just a small part of the intervention, but the entire procedure—the specific intervention, accessing the vessel, the closure, the catheterization, the supervision, and interpretation,” says Jillian Harrington, MHA, CPC, CPC-P, CPC-I, CCS-P, MHP, president and CEO of ComplyCode in Binghamton, NY.

The new codes differentiate between the vessels involved (iliac, femoral/popliteal, tibial/peroneal) and by the specific procedure the interventionalist performs (angioplasty, stent placement, and/or atherectomy). The AMA also created four add-on codes (37222–37223 and 37232–37235) and five Category III codes (0234T–0238T) for transluminal peripheral atherectomies.

Although the new codes are much more inclusive, coders can still report some services separately, so make sure you review the guidelines, says Melody W. Mulaik, MSHS, CPC, CPC-H, RCC, president of Coding Strategies, Inc., in Powder Springs, GA. “So it’s important to know what can be billed separately and when it is appropriate to bill those things separately.”

For example, a provider performs a renal stent placement in conjunction with lower extremity revascularization. In addition to the lower extremity procedure, you would also code:

- 36245 for the selective catheter placement for the first-order, lower-extremity artery branch
- 75722-59 for the renal angiography with the modifier to denote a distinct procedural service
- 37205-59 for the stenting of the initial vessel
- 75960-59 for supervision and interpretation of the stent placement

Different territory, different rules

Different rules govern each territory for the revascularization codes, so be sure to review them. For example, for the iliac vascular territory, coders should assign a single primary code for the initial iliac artery treated in each leg (37220 or 37221). If the physician treats additional iliac vessels in the same leg, assign the appropriate add-on codes (37222, 37223). Coders may assign up to two add-on codes in the unilateral iliac vascular territory because the physician can treat three vessels. Only use the add-on codes when the physician treats a different vessel. Do not use them to report distinct lesions within the same vessel.

For the femoral/popliteal territory, coders should assign a single interventional code for all segments of the common, deep, and superficial femoral arteries and the popliteal artery, regardless of what combination of angioplasty, stent, and/or atherectomy the physician uses. No add-on codes are used for this territory.

“They need to make sure they are looking at the rules for that specific territory and not mixing them up,” Mulaik says. She recommends coders find good interventional resources, such as specific interventional radiology coding books, to help with the coding.

Physicians generally document these procedures well, Mulaik says, but coders should be on the lookout for
changes in clinical patterns. Watch to make sure that physicians aren’t suddenly bringing patients back in so they can bill for separate procedures.

“That’s a hard thing because coders obviously don’t interfere with what their physicians are doing, but I think they have an obligation that if all of a sudden we see a change in the clinical practice and it appears to be financially motivated, I think we need to say, ‘Wait a minute, why are you doing that?’” Mulaik says.

The more inclusive codes will make the coding more straightforward because coders will now select the most comprehensive code. For example, coders used to have to evaluate each situation to determine when it was appropriate to code for both an angioplasty and a stent placement. Now they won’t have that question, Mulaik says.

“It cuts down a little bit on the decision-making process.”

One downside to the new codes may be lower reimbursement. “The problem is any time you combine codes, as a general rule, you’re going to see less money on the physician side,” Mulaik says. Practices and facilities will need to keep an eye on their payers to make sure the payer reimburses them when they appropriately code separate procedures, she says.

**Cardiac catheterization codes**

For cardiac catheterization procedures, the AMA made substantial changes to the guidelines. Here are some of the highlights. According to CPT guidelines, coders should not report code 93503 with any other diagnostic cardiac catheterization. When a provider performs a right heart catheterization in conjunction with other cardiac catheterization services, select the appropriate code from 93453, 93456, 93457, 93460, or 93461. Right heart catheterization does not include right ventricular or right atrial angiography. Report those procedures using code 93566.

Cardiac catheterization codes 93452–93461 include contrast injections, imaging supervision and interpretation, and a report on the imaging that is typically performed. Left heart catheterization codes 93452–93453 and 93458–93461 include intraprocedural injections for left ventricular or left atrial angiography, imaging supervision, and interpretation, when performed. For coronary catheter placement, codes 93454–93461 include intraprocedural injections for coronary angioplasty, imaging supervision, and interpretation. Be sure to completely review the guidelines for these codes to make sure you understand what is and is not included in the new codes.

The AMA also deleted many of the codes in the 93501–93556 series and replaced them with codes 93451–93468. Also look for these new Category III codes:

- 0223T–0225T, acoustic cardiography
- 0254T–0255T, endovascular repair of iliac artery bifurcation
- 0256T–0257T, implantation of catheter-delivered prosthetic aortic heart valve
- 0258T–0259T, transthoracic cardiac exposure for catheter-delivered aortic valve replacement

The new codes contain basically the same information as the old codes, but instead of having separate codes for components of the procedure, coders will now use one inclusive code, Harrington says. For example, code 93452 includes the left heart catheterization, intraprocedural injection(s) for left ventriculography, and the imaging supervision and interpretation, when performed.

Consider another example. A patient comes in for a left heart catheterization, selective coronary angiography, and left ventriculogram.

For 2010, coders would assign five codes:

- 93510 for the retrograde left heart catheterization
- 93543 for the left ventricular angiograph
- 93545 for the injection procedure during heart catheterization
- 93555 for the interpretation and report of the injection procedure during cardiac catheterization, ventricular and/or atrial angiography
- 93556 for the interpretation and report for injection procedure of the arteries

Beginning in 2011, however, coders will use a single code: 93458, which includes catheter placement.

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Coding resource: Endovascular revascularization

CPT codes 37220–37235 are to be used to describe endovascular procedures performed percutaneously and/or through open surgery exposure for occlusive disease, and all of these codes include the work of: accessing and selectively catheterizing the vessel, traversing the lesion, radiological supervision and interpretation directly related to the intervention(s) performed, embolic protection.

CODING TIPS:

- When treating multiple territories in the same leg, one primary revascularization code is used for each territory treated; add-on codes are used for second or third vessel(s) in the iliac and/or tibial/peroneal territories.

- When treating multiple vessels in multiple territories in a single leg at the same setting, the primary code for the treatment in the initial vessel in each vascular territory is reported; add-on codes are used when second and third iliac and/or tibial/peroneal arteries are treated in addition to the initial vessel in that vascular territory.

- If a lesion extends across the margins of one vessel vascular territory into another, but can be opened with a single therapy, this intervention should be reported with a single code despite treating more than one vessel and/or vascular territory.

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If used, closure of the arteriotomy by any method, and imaging performed to document completion of the intervention in addition to the intervention(s) performed. These codes include balloon angioplasty (e.g., low-profile, cutting balloon, cryoplasty), atherectomy (e.g., directional, rotational, laser), and stenting (e.g., balloon-expandable, self-expanding, bare metal, covered, drug-eluting).

➤ For bifurcation lesions distal to the common iliac origins which require therapy of two distinct branches of the iliac or tibial/peroneal vascular territories, a primary code and an add-on code would be used to describe the intervention. **Note:** In the femoral/popliteal territory, all branches are included in the primary code, so treatment of a bifurcation lesion would be reported as a single code.

➤ When treating the same territory(ies) of both legs in the same session, modifiers may be required to describe the interventions. Use modifier -59 to denote that different legs are being treated, even if the mode of therapy is different.

➤ Mechanical thrombectomy and/or thrombolysis in the lower extremity are sometimes necessary to aid in restoring flow to areas of occlusive disease, and are reported separately. ■
in coronary artery(s) for coronary angiography, intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation, and left heart catheterization, including injection(s) for left ventriculography.

Coding for cardiac catheterization for congenital cardiac abnormalities remains basically the same, using codes 93530–93533. When contrast injections are performed with the cardiac catheterization, select the appropriate code from 93563–93568.

Wound care coding revisions part of CPT surgery changes

The AMA added 62 new CPT codes in the surgery section and revised 55 other codes. The 2011 update includes extensive changes to the integumentary system and revised guidelines for skin replacement surgery and skin substitutes. The AMA also significantly changed the cardiac catheterization and revascularization codes.

Integumentary system

The majority of the integumentary system changes involve debridement. The AMA deleted the codes for skin-only debridement (11040 and 11041). “In order to use the codes in the integumentary section, it needs to go down to the subcutaneous level,” says Jillian Harrington, MHA, CPC, CPC-P, CPC-I, CCS-P, MHP, president and CEO of ComplyCode in Binghamton, NY.

For skin-only debridement, use revised codes 97597 and 97598. These codes include:

➤ Debridement using high-pressure waterjets
➤ Sharp selective debridements with scalpels, scissors, or forceps
➤ Open wound debridements

The AMA revised the codes to include a wider set of techniques for the skin debridement.

Coders may know these as physical therapy debridement codes, says Harrington. Sometimes physical therapists perform these services, but other times wound care nurses or other practitioners perform them in a wound care setting.

The AMA removed the word “skin” from the code description of code 11042. Code 11042 now denotes the debridement of the first 20 sq. cm. of subcutaneous tissue.

Use the new resequenced add-on code (11045) for each additional 20 sq. cm. of subcutaneous tissue debrided.

You’ll also notice revised wording for codes 11043 and 11044 and new resequenced add-on codes (11046 and 11047) for additional debridement areas.

Review the new guidelines for skin replacement surgery and skin substitutes (codes 15002–15005) because they more clearly define the conditions for reporting these services. Report these codes for removal of nonviable tissue when treating a burn, traumatic wound, or necrotizing infection, or for incisional release of scar contracture. Do not use these codes to report removal of nonviable tissue when treating a chronic wound.

Musculoskeletal system

The musculoskeletal system includes two new codes for anterior interbody approaches for arthrodesis (22551 and 22552). These codes include the discectomy, ostrophytectomy, and decompression of the spinal cord and/or nerve roots. “These are a little more comprehensive than the codes that are already in CPT,” says Harrington.

The AMA also added three new resequenced codes for surgical hip arthroscopy (29914–29916).

Respiratory system

In the respiratory section, look for three new codes for endoscopic dilation of the sinus ostium (31295–31297). The difference between the codes comes down to which sinus is being dilated, says Jennifer Avery, CCS, CPC-H.
CPC, CPC-I, senior regulatory specialist for HCPro, Inc., in Danvers, MA. The AMA also added new guidelines to the sinus endoscopy section to instruct coders that the three new codes include fluoroscopic guidance when performed. The guidelines also specify that the codes represent unilateral procedures. If the provider performs the procedure bilaterally, make sure you append the appropriate modifier.

A new parenthetical note clarifies how to report these codes with other procedures performed on the same sinus during the same session.

The AMA added 18 new codes to the digestive system section, including codes related to repair of a paraesophageal hiatal hernia (43332–43337), new codes for gastric intubation and aspiration (43753–43755), and codes for duodenal intubation and aspiration (43756–43757).

**Nervous system**

Look for eight new codes and nine revised codes in the nervous system. The AMA revised the parenthetical note for intraoperative neurophysiology to state that you should not report code 95920 if the recording is 30 minutes or fewer. If the procedure goes past midnight, you should report the service on the day on which monitoring began. “Be sure to read the parenthetical notes and pay attention to that information to utilize the codes correctly,” Avery says.

**Pain management**

In the pain management section, the AMA continues to revise the codes for the extracranial nerves, peripheral nerves, and autonomic nervous system (codes 64479–64484). The descriptions now make clear that fluoroscopic and CT guidance are included in the service. The revised parenthetical note for 64455 also states that the image guidance and contrast injections are included in codes 64479–64484. The AMA also added a parenthetical note directing coders to use 0228T and 0229T for ultrasound guidance, which is not included in the code description.

“If you are reporting ultrasound guidance, you want to make sure you report that T code,” says Avery. “Even though insurance companies might not recognize those, it’s important to get the data out there.”

The AMA also added new codes for neurostimulators: 64566 for posterior tibial nerves and 64568–64570 for cranial nerves. Code 64568 includes placement of both the electrode array and the pulse generator, while code 64569, used for revision or replacement of cranial nerve stimulator array, includes connection to an existing pulse generator. The removal code, 64570, includes removal of the electrode array and the pulse generator. That makes these codes unique because in other areas such as spinal neurostimulators (63650–63688), coders can report separate codes for the array and pulse generator, Avery says. “Now the AMA is starting to look at things more as a system.”

You won’t find code 61795 for stereotaxis any longer. The AMA deleted the code and replaced it with three new add-on codes—61781–61783—that denote where the stereotaxis is used. Be sure to check the exclusionary notes for these codes, says Avery. 

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Editor’s note: Beginning this month, Briefings on APCs will include a question-and-answer section each month. The answers are provided based on limited information submitted to Briefings on APCs. Be sure to review all documentation specific to your own individual scenario before determining appropriate code assignment.

If you have a question you would like us to address, please e-mail your question to Senior Managing Editor Michelle Leppert at mleppert@hcpro.com.

ED observation coding

With regard to ED observation coding, how many chief complaints should I code? I always thought you chose the chief complaint that best matched the final diagnosis and if there were other chief complaints you coded them as secondary codes to support any tests performed. Is this incorrect?

ED services are most often classified as outpatient. Observation services can be categorized as either outpatient or inpatient. Several applicable guidelines from Section IV (Diagnostic coding and reporting guidelines for outpatient services) of the 2011 ICD-9-CM Official Guidelines for Coding and Reporting provide the answers to your questions.

You mentioned a “final diagnosis” and “the chief complaint that best matched the final diagnosis.” Once you have a final diagnosis, you may not code any additional inclusive signs or symptoms (chief complaints).

Section IV, part E (Codes that describe symptoms and signs) explains that the “chief complaints” are only to be reported when the provider hasn’t established a final diagnosis. It is part of a professional coding specialist’s job to know (or learn) which signs and symptoms are included in the final diagnosis. Coders should not report them separately.

For those cases in which additional signs and symptoms support medical necessity for tests and other services and the provider does not determine a confirmed diagnosis, report the additional signs and symptoms separately, as directed in Section IV, part I (Uncertain diagnosis) of the guidelines.

Section IV answers your question regarding how many chief complaints you should code. According to part K (Code all documented conditions that coexist), “Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management ...”

Contributors

We would like to thank the following contributors for answering the questions that appear on pp. 10–12:

Andrea Clark, RHIA, CCS, CPC-H
President
Health Revenue Assurance Associates
Plantation, FL

Christine Garvey, FNP, MSN, MPA, FAACVPR
Manager
Seton Pulmonary & Cardiac Rehabilitation
Daly City, CA

Karen Lui, RN, MS
Legislative and Regulatory Analyst
GRQ Consulting, LLC
Vienna, VA

Shelley C. Safian, MAOM/HSM, CCS-P, CPC-H, CHA
President
Safian Communications Services
Orlando, FL

Denise Williams, RN, CPC-H
Director of Revenue Integrity Services
Health Revenue Assurance Associates, Inc.
Plantation, FL
Billing for Unna boot

I have two questions about Unna boots. Can two Unna boots be billed on the same day? If so, do we need to use a modifier? Can we bill 97602 (wound dressing) and 29580 (application of an Unna boot) on the same day? If so, should we append modifier -59 or a different modifier?

To answer your question, I need more specific information. One of the key pieces of missing information is whether this is all treating the same wound.

First, code 97602 does not report a wound dressing—it reports wound care (non-selective debridement, wound assessment, and instructions for ongoing care). Therefore, I am not certain which part of your question is the error: the code you wrote (97602) or the description (wound dressing). I cannot respond to this portion of your question.

If you are applying a standard wound dressing to one wound, and the Unna boot to treat a different wound on a different part of the body, you may report both using modifier -51 (multiple procedures). Of course, the claim form will connect each of these procedures to different diagnosis codes, so that should make everything clear.

If you are referring to the care of one ulcer only, or two ulcers on one extremity that would both be covered by one Unna boot, the answer would be no; you cannot report a wound dressing and an Unna boot for the same extremity on the same day, because the Unna boot is a type of wound dressing.

An Unna boot is a wound dressing of a gauze bandage moistened with zinc oxide, calamine lotion, and glycerine. This is specifically used to encourage healing and reduce infection for a skin ulcer, virtually always on the leg. This gauze is wrapped to cover the ulcer and extends the length of the lower leg (below-the-knee to the ankle or foot). Once applied, it hardens, and then an elastic bandage is wrapped over the Unna boot. Standard of care states that an Unna boot is applied every one to two weeks until the ulcer heals.

Therefore, your question about two Unna boots on one day needs additional detail. If Unna boots are being applied on the right leg and the left leg of the same patient on the same day, then modifiers would be required—using 29580-RT and 29580-LT or 29580-50 depending upon the direction of the payer.

If there is medical necessity to reapply an Unna boot on the same leg of the same patient on the same day, supporting documentation should be included to explain why this is required.

Charging for drug administration in ED by nurse

A patient comes into the ED and the nurse administers drugs as an injection or IV. Do we charge an administration fee for this? Would the nurse need to document a start and stop time? Or would it be a specific charge determined by what the drug is and how it is administered? Would the charge be a part of the drug charge itself? I want to make sure we are charging this appropriately to Medicare.

If Medicare does pay for an administration fee, how much would it pay in a percentage figure?

Medicare recognizes the drug administration codes in the CPT® manual, and hospitals should use them in accordance with their definitions and the documentation for the services they render.

Because drug administration codes are time-based, the nurse or the physician must document information to support the code reported. Time-based administration services require a start and stop time to accurately reflect the total time.

Depending on other services rendered during the same encounter, payers sometimes consider drug administration services as an integral part of the other service.

For example, the administration of pain medication following a procedure is an integral part of that procedure and not separately reportable. You must follow

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these coding rules when assigning codes for an encounter. If the drug administration is considered integral to another service such that it cannot be coded separately, the charge representing the cost of the services should be reflected on the claim. This can be accomplished by either including the cost/charge in the other service or by reporting a separate line without the drug administration HCPCS code.

Not reporting the HCPCS code ensures that the charge/fee is reflected for future rate-setting, but no separate payment is received for a service that is paid as part of another service.

For the episode you mention, if a covered drug is administered, the facility would charge for the drug and its administration as long as the documentation in the record supports the service provided.

Medicare reimbursement is based on the APC for hospitals subject to OPPS; for facilities not subject to APC reimbursement, the usual payment methodology would hold.

Using same staff for cardiac and pulmonary rehab

Can you mix pulmonary and cardiac rehab patients together as long as you have the appropriate staffing for both?

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You obviously cannot mix the education because the impairment associated with each disorder is quite different. So be sure you’re doing the education completely separately and documenting that. You could overlap the exercise as long as you’re treating the individual needs of each patient based on the Medicare requirements.

Pulmonary rehabilitation patients are much more similar to congestive heart failure patients than they are to patients that are recovering from a myocardial infarction. So it has to be clinically appropriate care by staff that have demonstrated competency in the clinical care of that population.

That’s the clinical response.

The regulatory response is that in June 2006, Medicare took out the exclusive-use terminology that had restricted cardiac rehab from mixing with any other population.

They intentionally removed that.

However, one local Medicare contractor—for J4 in Texas, Oklahoma, Colorado, and New Mexico—has proposed to keep the exclusive-use language in its cardiac rehab local coverage determination.

I don’t think it would be in writing anywhere that you cannot mix the patient populations of both cardiac and pulmonary rehabilitation.
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Sincerely,

Lauren McLeod
Publisher
HCPro, Inc.

75 Sylvan Street • Suite A-101 • Danvers, MA 01923 • Phone: 781/639-1872 • Fax: 781/639-7857 • Web: [www.hcpro.com](http://www.hcpro.com)