Resolve continuing questions about injection and infusion coding

Not much has changed with injection and infusion coding in recent years. After all, coders still follow the hierarchy when choosing codes, and the AMA only added one new code for 2011. But common questions still remain about proper documentation, modifier -59 use, and integral drug administration services.

Time documentation requirements

With all of the auditing and intense scrutiny of hospital records, services billed need proper substantiation in the supporting documentation, says Valerie Rinkle, MPA, revenue cycle director for Asante Health System in Medford, OR. That documentation is a combination of practitioner and nurse documentation.

“From my perspective, it’s always going to start with the physician or practitioner order,” Rinkle says. Then she moves on to the execution of that order. Before selecting a code, coders must determine:

➤ Substance being infused
➤ IV site
➤ Flow rate
➤ Start and stop times

“Because drug administration services are time-based codes, the AMA in CPT has made it quite clear that the documentation must reflect time, in best practices, to support those time-based codes,” Rinkle says.

Individuals who charge or code for drug administration services, such as nurses at the point of care or coders in HIM, also need to remember the various reporting requirements of services related to time. For example, an infusion that lasts for 15 minutes or less must be reported as an IV push injection, which is still unintuitive and therefore problematic for charging and coding staff, says Jugna Shah, MPH, president of Nimitt Consulting Inc. based in Washington, DC.

“Because drug administration services are time-based codes, the AMA in CPT has made it quite clear that the documentation must reflect time, in best practices, to support those time-based codes.”

—Valerie Rinkle, MPA

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Injection and infusion coding

The AMA along with several FIs/MACs recommend that providers document start and stop times. However, no one seems to be saying that times are “required”, yet accurate charging or coding from a compliance defense perspective simply cannot occur without specific start and stop times, says Shah.

In Chapter 4 of the Claims Processing Manual, CMS instructs providers to report codes according to CPT guidelines. CMS specifically mentions that CPT instructs coders to use the actual time during which the infusion is administered for time-based codes. CMS also notes that it has the expectation that actual time would be documented in order to select CPT codes for drug administration services accurately.

Various contractors have also weighed in on documentation requirements. In a December 2006 FAQ, Kansas Medicare stated its interpretation that the actual infusion start and stop times should always be documented.

In December 2009, AdminaStar released an FAQ stating, “A reviewer must be able to determine the actual amount of time a medication infused from the records, not just the ‘ordered’ infusion time.” In addition, AdminaStar stated that drug administration codes are time-based and, therefore, a time frame should be clearly documented.

Noridian also released guidance stating that providers should report stop times for all infusions. However, Noridian also provides a bit of an out, Rinkle notes. Noridian’s nurse reviewers can look at anything in the patient’s record to ascertain the total clinical picture and determine the appropriateness of payment.

Make sure you know your MAC’s or FI’s requirements because Noridian points out that reviewers from other organizations may utilize a different approach. “I’m not so sure the RACs are going to be as generous as [Noridian],” Rinkle warns.

Shah agrees and believes that most reviewers will simply look for specifically documented start and stop times to support drug administration services rather than looking to piece together the overall infusion time based on an order, documentation, flow rate, etc. Therefore, getting to a best practice of having well documented start and stop times is worth the investment of time and energy that it may take, she says.

Infusions without a stop time

WPS Medicare, a MAC, states, “Start and stop times must be clearly documented in order to request Medicare payment for infusion services. In the absence of start and stop time, providers may only request reimbursement at the IV push level.”

“This is somewhat controversial,” Rinkle says. “Do you charge an IV push and receive an APC payment if you don’t have a stop time even though an infusion was ordered and administered?”
CMS has not specifically stated what providers should do when a stop time is missing, but we do know from CMS and CPT that infusions that are 15 minutes or less must be reported as IV pushes. Therefore many have taken this to mean that if an infusion is ordered, and documented as being administered, then without a stop time, at a minimum all we can know is that it must have at least run for a short duration and thus required to be reported as an IV push,” says Shah.

Determine if your FI or MAC has a specific policy on this and if not, then determine what your facility considers to be best practice for what to charge if anything when a stop time is missing on infusions that are provided. Also look at what you are doing at your facility to improve compliance with the documentation requirements.

Facilities do face a compliance risk if they report infusions based solely on start times, flow rates, and orders, without any stop times or a continuing quality improvement project for your documentation, Rinkle says. “Remember, if it wasn’t documented, it wasn’t done, and there is going to be increased scrutiny of our documentation. How are you going to substantiate the charges you billed if you don’t have appropriate documentation?”

**Hydration times**

Coders only have two hydration codes to choose from (96360 and 96361), so it might seem that coding hydration should be easy. However, coders do need to keep some rules in mind.

Hydration must run for more than 30 minutes in order to be reported. If the hydration lasts for 30 minutes, do not report it using the hydration codes, says Shah.

CPT has indicated that hydration that runs for less than 30 minutes should be reported with the unlisted code 96379, but others have indicated that this should be reported with a revenue code and dollar charge.

What about hydration that is stopped and started multiple times? For example if a patient receives two 20 minute hydrations? In this instance, providers are asking whether they can add the times of the two hydration sessions together and report a hydration code. Many years ago, when hospitals reported HCPCS Q codes, the total duration would be added together and the total time would be reported using the appropriate code. Not anymore, Shah says.

“Whether we’re talking about hydration or a therapeutic infusion, the rule of thumb is that each infusion, per its separate start and stop time, must be looked at on its own to see if it meets the time criteria,” Shah says.

Remember that hospitals cannot report hydration when the fluids are used solely to administer drugs or to keep a line open. The administration of fluid is incidental hydration and should not be billed, Shah says.

Do not report hydration running concurrent to another infusion or during chemotherapy, per CPT instructions. “However, medically necessary hydration provided before or after chemotherapy is appropriate to charge,” Shah says.

**Modifier -59**

When considering whether to append modifier -59, coders first need to review the clinical situation and the documentation. Use modifier -59:

- If two vascular access sites are started
- If multiple encounters occur on the same date of service
- Only when appropriate to bypass medically unlikely edits and NCCI edits

Coders should use modifier -59 with two different drug administration services only if the patient receives drug administration in two completely separate vascular access sites. Report an initial service for each site and each subsequent service based on what the providers documented and actually administered through each specific site, Rinkle says. For whatever you consider the second site, append modifier -59 to those codes.

“Always make sure you have the appropriate documentation before appending that modifier because we all know there is a lot of data mining going on regarding use of that modifier,” Rinkle says.

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Drug administration integral to other services

If the drug administration service is typically performed pre- or post-procedure, then do not separately report it because it is considered integral, Rinkle says. Examples of drug administration integral to a procedure include but are not limited to:

➤ Infusion of anesthetic for surgery
➤ Preop antibiotic injection/infusion
➤ Postop pain and/or nausea injections
➤ Contrast media injections for CT exams
➤ Injections for sedation analgesia

“That’s protocol for that procedure that you would initiate the drug administration services as a component of performing that procedure,” Rinkle says. Do not report those services with drug administration codes for separate APC payment. However, because these services represent an additional cost to the facility, you can report those charges in a way that represents the cost of care without generating a separate payment from the global procedure for which you report the CPT code, she says.

If drug administration services are not typical for the procedure and you can clearly see that the physician is ordering it for a comorbid condition, you can separately report it, Rinkle says.

Examples include an anti-thrombolytic injection given either pre- or post-surgery, or an anti-hypertensive injection. Not all patients would receive those particular injections because not all patients have those conditions. “That is when it would be medically necessary and supported by the documentation that it is not integral to the procedure,” Rinkle says.

Brush up on hemorrhoid coding: Know types, treatments

by Lori-Lynne A. Webb, CHDA, CCS-P, CPC, COBGC, CCP

Hemorrhoids are the great unmentionable in our list of ailments. Some people never suffer from them; for others, they cause excruciating pain. As a coder, you must understand the different types of hemorrhoids and their treatments to code correctly for this malady.

A hemorrhoid is a condition in which the vein(s) around the lower rectum or anus are swollen and inflamed. Both men and women suffer from hemorrhoids. Most people over the age of 50 have suffered from them, and pregnant women commonly complain of them.

Internal hemorrhoids are caused by increased pressure within the internal hemorrhoidal vein. External hemorrhoids occur due to increased pressure within the external hemorrhoidal vein. You may also encounter a thrombosed hemorrhoid, which is an internal or external hemorrhoid that contains a blood clot within the vein itself.

Hemorrhoidal treatments vary, and as a coder, you will need to know those treatments and their documentation requirements. You can use the operative report on pp. 6–7 to check your understanding of how to code hemorrhoid procedures.

Diagnosing the hemorrhoid

Internal hemorrhoids are found in the ICD-9-CM Manual under codes 455.0–455.9.

For internal hemorrhoids, the provider may perform a digital rectal exam in the office and may also perform an anoscopy or proctoscopy/sigmoidoscopy, depending on the symptoms. If the anoscopy is performed in an outpatient hospital or ambulatory surgery setting, the provider can use anesthesia for a better diagnostic look via endoscopy or visual and digital examination, and also provide comfort for the patient.

A physician usually diagnoses external hemorrhoids in an office setting with a visual and/or digital inspection.
around the anal/rectal area. This type of visit can be coded as a routine office visit E/M code.

Diagnostic interventions can include the following procedures:
- Digital rectal exam, an E/M exam in the office or outpatient setting (CPT codes 99201–99215)
- Anorectal exam requiring anesthesia (45990)
- Anoscopy (46600–46615)
- Sigmoidoscopy (HCPCS code S0601, screening proctoscopy, for use with private payers only)
- Rigid proctosigmoidoscopy (ICD-9-CM code 48.23)
- Proctosigmoidoscopy with biopsy (48.24)
- Endoscopy (CPT codes 45300–45345)

### Treating the Hemorrhoid

Once the provider diagnoses hemorrhoids, he or she may recommend an over-the-counter (OTC) intervention or at-home/self-performed therapy, such as one of the following:
- Ice packs (for external hemorrhoids)
- Warm baths
- Increased fluids and fiber in the diet, including fiber supplements such as psyllium or methylcellulose
- Stool softeners
- OTC creams and ointments to help with itching or inflammation
- A compress soaked in witch hazel
- A pain reliever, such as acetaminophen, ibuprofen, aspirin, or naproxen sodium

If OTC or home therapy does not work, the provider may recommend an in-office or surgical intervention. The AMA has changed the relevant CPT codes over the past few years to include details of the hemorrhoid, such as internal, external, or thrombosed. The AMA also created combination codes for when the provider surgically treats internal and external hemorrhoids in the same operative session.

Review the operative report carefully to determine whether the provider treated a single type or both types of hemorrhoids.

Outlined below are the CPT codes and the ICD-9-CM Volume 3 procedure codes.

**External hemorrhoid procedures:**
- 46083, incision of thrombosed hemorrhoid, external
  - 49.47, evacuation of thrombosed hemorrhoids
- 46230, excision of external hemorrhoid papillae or tags, anus
  - 49.46, excision of hemorrhoids (NOS)
- 46250, hemorrhoidectomy, external, two or more columns/groups (Note: For hemorrhoidectomy, external, single column/group, use 46999)
  - 49.46, excision of hemorrhoids (NOS)
- 46320, excision of thrombosed hemorrhoid, external hemorrhoid
  - 49.47, evacuation of thrombosed hemorrhoids
  - 49.43, cauterization of hemorrhoids
  - 49.46, excision of hemorrhoids

**Internal hemorrhoid procedures:**
- 46614, anoscopy with control of bleeding
  - 49.43, cauterization of hemorrhoid
- 46500, injection of sclerosing solution, hemorrhoids
  - 49.42, injection of hemorrhoids
- 46221, hemorrhoidectomy, internal, by rubber band ligation(s)
  - 49.45, ligation of hemorrhoids
- 46930, destruction of internal hemorrhoid(s) by thermal energy (e.g., infrared coagulation, cautery, radiofrequency)
  - 49.49, other procedures on hemorrhoids

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Hemorrhoid coding < continued from p. 5

- 46945, hemorrhoidectomy, internal, by ligation other than rubber band; single hemorrhoid column/group
  - 49.46, excision of hemorrhoids (NOS)
- 46946, hemorrhoidectomy, internal, by ligation other than rubber band; two or more hemorrhoid columns/groups
  - 49.46, excision of hemorrhoids (NOS)
- 46947, hemorrhoidopexy (e.g., for prolapsing internal hemorrhoids) by stapling
  - 49.49, other procedures on hemorrhoids

Note that ICD-9-CM Volume 3 includes additional procedure codes that do not necessarily cross-code to CPT completely. Therefore, before choosing your codes, review the code and the operative report thoroughly.

ICD-9-CM Volume 3 codes that do not cross-code completely to CPT codes include the following:
- 49.43, cauterization of hemorrhoid
- 49.41, reduction of hemorrhoid
- 49.44, destruction of hemorrhoid by cryotherapy

Combination CPT codes for surgical intervention of internal and external hemorrhoids:
- 46255, hemorrhoidectomy, internal and external, single column/group
  - 49.46, excision of hemorrhoids (NOS)

Check your hemorrhoid coding with this operative report

So now you know everything there is to know about coding for hemorrhoids, right? Well, here’s your chance to find out. Read the following operative report and try to code it yourself.

Lori-Lynne A. Webb, CHDA, CCS-P, CPC, COBGC, CCP, provides her take on the correct codes at the end.

Operative report
- Preoperative diagnosis: Thrombosed hemorrhoids.
- Postoperative diagnosis: Same.
- Procedure performed: Hemorrhoidectomy times three.
- Surgeon: Dr. Abeecee.
- Anesthesia: General.
- Findings: Large, circumferential prolapsed hemorrhoids, with partial thrombosis. Three of the largest hemorrhoids were excised without complication. Some hemorrhoidal tissue remains at the conclusion, but I did not feel it was safe to do any further excision.
- Specimen: Hemorrhoids.
- Cultures: None.
- Drains: None.
- Estimated blood loss: 50 cc.
- Dressings: Xeroform pack and ABD.
- Complications: None.
- Condition: Stable.

Operative indications
Patient is a 20-year-old pregnant female who presented to my clinic with excruciatingly painful hemorrhoids. She had had a previous thrombosed hemorrhoid that was incised and drained in the clinic earlier in the pregnancy. She has not had a bowel movement in a week due to pain. On exam, she had circumferential prolapsed hemorrhoids with partial thrombosis in multiple areas. I discussed hemorrhoidectomy with the patient and her sister. They understood and wished to proceed.

Description of procedure
The patient was identified in the holding area and brought to the OR where she was placed in the supine position. After induction of general anesthesia, she was prepped and draped in the usual sterile fashion. The legs were brought up in the lithotomy position and a retractor was placed in the anus. A very prominent, large, partially thrombosed, external hemorrhoid was identified at 7–8 o’clock in the lithotomy position. It was grasped with a hemorrhoidal clamp. A 2-0 chronic stitch was placed at the apex. Bovie electrocautery was then used to elliptically excise the large hemorrhoid, staying superficial to the sphincter muscle. Hemorrhoid was then passed off as specimen. Further
➤ 46260, hemorrhoidectomy, internal and external, two or more columns/groups
   – 49.46, excision of hemorrhoids (NOS)

As you review the above-mentioned codes, you will note that the treatment/procedure codes include terminology such as incision, excision, cauterization, ligation, reduction, and column/group. CPT now includes the “column/group” verbiage when identifying hemorrhoids, so the provider’s documentation should specify whether the hemorrhoids were a single column/group or two or more columns/groups, or whether the hemorrhoids were separately identifiable; the documentation should also identify the depth to which the procedure was performed.

Coders must understand the terminology and how the procedure is performed (e.g., incision, excision, reduction). When in doubt, review the terminology to clarify its meaning.

If you are unsure or unclear regarding the procedure itself, query your provider to obtain clarification. In some instances, a provider may need to amend the documentation in order to adequately describe the procedure.

If, after review, you don’t find what you are looking for, consider using the unlisted CPT code 46999 or a nonspecific ICD-9-CM code such as 49.49. If you do use an unlisted or nonspecific code, be prepared to validate your coding with the operative report and possibly chart notes from the office.

bleeding was controlled with Bovie electrocautery. The mucosa was closed with a running chromic stitch, leaving the end-point epidermis open.

Two other very large hemorrhoids with thrombosis were then identified, at the 5 o’clock position in lithotomy and at the 10–11 o’clock position. These two hemorrhoids were excised in the exact same fashion as the first hemorrhoid. At the conclusion, there was no evidence of bleeding. Some prominent hemorrhoidal tissue remained; however, I did not feel any further excision would be safe at this time.

Xeroform wrapped around 4x4s was then placed in the anus as a dressing and ABD placed over the top. The patient was then awakened and taken to the recovery room in good condition. There were no operative complications.

Coding the case

How would you code this case? Here’s how Webb sees it:

➤ CPT codes:
   – 46320 (excision of thrombosed hemorrhoid, external)
   – 46320 with modifiers -51 and -59
   – 46320 with modifiers -51 and -59
➤ Diagnosis: 455.4 (external thrombosed hemorrhoids)

➤ Rationale: In this case, the physician performed three separately identifiable procedures, denoted by the location: 7–8 o’clock position, 5 o’clock position, and 10–11 o’clock position. That’s why I appended modifiers -51 and -59.

I chose code 46320 rather than 46250 (hemorrhoidectomy, external, two or more columns/groups) because the physician noted he was staying “superficial” to the sphincter muscle. In code 46250, the physician dissects from the underlying sphincter muscle itself. In addition, the provider did not note that these hemorrhoids were within a column or group; therefore, I coded three separately identifiable hemorrhoids.

➤ ICD-9-CM Volume 3 code:
   – 49.43 (cauterization of hemorrhoids)
➤ Diagnosis: 455.4
➤ Rationale: I chose code 49.43 based on the notation in the operative report that the physician excised the hemorrhoid with electrocautery and clamping. However, you could use code 49.46 (excision of hemorrhoids) since the physician performed a hemorrhoidectomy. I personally believe 49.43 more accurately represents the procedure.
I/OCE edits: CMS switches around packaged, separately payable drugs, changes some APC status indicators

CMS changed the packaging status of several drugs and reduced the number of HCPCS codes available as part of the January I/OCE edits.

Some drugs that were packaged are now separately payable, while some separately payable drugs are now packaged. Thirteen APCs that previously had a status indicator of G (pass-through drugs and biologicals) now have a K (non-pass-through drugs and biologicals) status indicator.

Hospitals need to think about their drugs, what they are getting paid for separately, and what they code because CMS has changed the payment status of many drugs. “Always document and code all drugs and make sure claims include all drugs, whether you are paid for them separately or not,” says Dave Fee, MBA, product marketing manager, outpatient products, at 3M Health Information Systems in Murray, UT. “If there’s a HCPCS code, use it.”

HCPCS changes

CMS added 311 new HCPCS codes in January: 163 new CPT codes and 148 new HCPCS level II codes. With 391 HCPCS codes being deleted, there are now 80 fewer HCPCS codes than in 2010.

CMS added 31 new APCs, deleted 49, and changed the definitions of 15. CMS also reinstated three HCPCS codes that were previously deleted.

CMS initially announced that HCPCS codes L3660, L3670, and L3675 would be among the 12 HCPCS codes discontinued as of December 31, 2010. However, the agency has reinstated the three codes effective January 1.

Code L3660 is used for figure-eight-design abduction restrainers, while L3670 represents acromioclavicular canvas and webbing orthosis. L3675 is for vest-type abduction restrainers.

Preventive services

In essence, Medicare is catching up with other insurers that already covered an annual physical, says Fee. In the past Medicare did not, but now it will cover a list of 15 preventive services.

In preamble table 48B of the 2011 OPPS final rule, CMS lists the general category, the specific HCPCS codes that are covered, and whether deductible and/or coinsurance apply. “Expanding coverage for preventive services will be a big benefit,” Fee says.

Pay attention to the deductible and coinsurance requirements for initial exams. Code G0402 (initial preventative exam, face-to-face) and G0404 (electrocardiogram, routine ECG with 12 leads; tracing only) can both be done during an initial visit, but G0404 has coinsurance and G0402 doesn’t. New modifier -PT (colorectal cancer screening test; converted to diagnostic test or other procedure) has implications related to preventive services. A patient comes in for colorectal cancer screening—which includes screening colonoscopy, flexible sigmoidoscopy, and barium enema—and during the course of that test, the physician switches to a diagnostic colonoscopy. In some cases, the physician may need to perform a biopsy or remove a polyp. In those cases, the procedure is no longer screening.

In that scenario, the deductible for any surgical service the physician performs during that episode is waived. The question then becomes what is meant by surgical services. According to CMS Transmittal R7390TN, surgical procedures fall within the CPT code range of 10000-69999.

In these cases, code the diagnostic service, not the screening, and append the modifier -PT to the diagnostic service.

New modifiers

CMS added 13 modifiers. One of the new modifiers, -CS (item or service related, in whole or in part, to an illness, injury, or condition that was caused by or exacerbated by the effects, direct or indirect, of the 2010 oil spill in the Gulf of Mexico, including but not limited to subsequent cleanup activities), is related to the oil
spill in the Gulf and has an effective date retroactive to April 20, 2010. The remaining modifiers became effective January 1.

Six of the new modifiers—-4P, -4Q, -4R, -4S, -4T, and -4U—are additions to Appendix I (genetic testing coder modifiers) of the CPT Manual. These modifiers fall under the histocompatibility/blood typing/identity/microsatellite section and are used for genetic fingerprinting.

The remaining new modifiers are:

➤ -AY: Item or service furnished to an end stage renal disease (ESRD) patient that is not for the treatment of ESRD
➤ -AZ: Physician providing a service in a dental health professional shortage area for the purpose of an electronic health record incentive payment
➤ -DA: Oral health assessment by a licensed health professional other than a dentist
➤ -GU: Waiver of liability statement issued as required by payer policy, routine notice
➤ -NB: Nebulizer system, any type, FDA cleared for use with specific drug
➤ -PT: Colorectal cancer screening test; converted to diagnostic test or other procedure

**Critical care**

CMS added some definition to critical care code 99291 (initial critical care) in the I/OCE specifications. CMS will package certain ancillary services that have status indicator Q3 (codes subject to payment as part of a composite) with that critical care service unless modifier -59 (distinct procedural service) is appended.

However, there is one exception to that exception, Fee says. Codes 36600 and 94762, which previously had a Q1 status indicator and were changed to a Q3 status indicator, will be packaged no matter what. “I think it’s really important that people understand that this has now been defined,” Fee says.

The packaged services include:

➤ Interpretation of cardiac output measurements (93561, 93562)
➤ Chest x-rays (71010, 71015, 71020)

➤ Blood draw for specimen (36415)
➤ Blood gases and information data stored in computers (99090)
➤ Gastric intubations (43752, 43753)
➤ Pulse oximetry (94760, 94761, 94762)
➤ Temporary transcutaneous pacing (92953)
➤ Ventilator management (94002-94004, 94660, 94662)
➤ Vascular access procedures (36000, 36410, 36415, 36591, 36600)

For example, if a patient comes in for critical care and undergoes a chest x-ray, it will be packaged with the critical care code. If the patient undergoes a different type of x-ray, such as an abdominal x-ray, CMS will pay for it separately.

**Therapy discounting**

CMS’ multiple procedure payment reduction applies to all therapies, including speech, occupational, and physical therapy. The 2011 Medicare Physician Fee Schedule included considerable discussion of the idea that each type of therapy is its own discipline. When a patient comes into a facility, he or she sees different therapists—one for physical, one for occupational, and so on. Commenters questioned how CMS could treat them as the same. CMS decided that even though the therapies may be different disciplines, it will treat them as one and apply the payment reduction.

In the rule, CMS refers to the “same provider,” and it considers both physicians and facilities to be providers. So for a facility that bills all of the services on the same date on the same claim, CMS will consider the facility as a single provider, even if the patient saw different therapists at the facility. As a result, the facility’s services will be paid 25% less for each additional service or additional instance of the same service.

CMS created a priority list stating that it will pay 100% for the procedure with the highest practice expense, with the remaining therapies paid at 75%.

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Coders still need to append the appropriate modifier to any code on the list of “always therapy” codes. Those modifiers are:
- [GN]: Services delivered under an outpatient speech-language pathology plan of care
- [GO]: Services delivered under an outpatient occupational therapy plan of care
- [GP]: Services delivered under an outpatient physical therapy plan of care

**Free or reduced-cost devices**

If a facility receives a device at no cost, coders or billers must add modifier -FB (item provided without cost to provider, supplier, or practitioner) to the code. For 2011, CMS expanded that modifier to include radiopharmaceuticals as well.

CMS has a table on its website that shows, for certain procedures, a certain percentage of the dollars that represent the device, known as the offset amount. “I don’t think you’ll see that with radiopharmaceuticals because they are billed separately and they are not bundled into procedures at this time,” Fee says. ■


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**Correct usage of code 57156**

I have a question about new CPT code 57156 (insertion of vaginal radiation afterloading apparatus for clinical brachytherapy). Our institution has historically used 57155 (insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy) for both tandem and ovoid insertion and vaginal cylinder insertion. When would we use 57156?

CPT code 57156 is a new code for 2011. The AMA’s reference, 2011 CPT Changes: An Insider’s View, provides no additional rationale as to the purpose of the code except what is included in the descriptor. The most apparent difference between these codes (57155 and 57156) is in the anatomical wording: “uterine” in code 57155, “vaginal” in code 57156. Additionally, 57156 is for insertion of an afterloading apparatus, which is not present in the CPT code description of 57155.

The American Society for Therapeutic Radiology and Oncology (ASTRO), the world’s leading organization devoted to radiation oncology, typically provides coding guidance in this difficult coding area. A recent ASTRO News article on the 2011 OPPS final rule discusses 57156.

According to the article, this code would be used for the placement of a vaginal cylinder, ovoids, or similar afterloading device for subsequent brachytherapy, typically in a post-hysterectomy patient. ASTRO also indicates that the code was developed due to lack of a specific CPT code describing this procedure and the ambiguity in the description of CPT code 57155. ASTRO found that this was causing some providers to use code 57155 for post-hysterectomy placement of a vaginal afterloading device for brachytherapy.

With the establishment of this code, coders now have a method to report placement of devices for brachytherapy into only the vagina when the uterus is absent. The
University of Washington (UW) Physicians, which is the practice group for physicians and healthcare providers associated with UW Medicine in Seattle, recommend the following documentation be included for this procedure:

➤ Positioning of the patient and visualization of the vaginal cuff
➤ Measuring of the vagina and determination of the size of brachytherapy apparatus that can be placed
➤ Dilation to release any post-radiation adhesions
➤ Placement of the device into the vagina with assessment of fit and stability and any adjustment required for fit
➤ Confirmation of location by x-ray
➤ Measurements of applicator position in relation to the perineum
➤ Securing of the applicator base plate locking mechanism

Subsequent observation and prolonged services

New subsequent observation care codes 99224–99226 have approximate time indicated, while the already existing observation codes (99218–99220) are per day. Are the new codes billable with outpatient prolonged services codes 99354–99355?

The AMA created the following new codes effective January 2011 to report subsequent observation services in the hospital setting:

➤ **99224**: Subsequent observation care per day, low level. Physicians typically spend 15 minutes at the bedside and on the patient’s hospital floor or unit.
➤ **99225**: Subsequent observation care per day, middle level. Physicians typically spend 25 minutes at the bedside and on the patient’s hospital floor or unit.
➤ **99226**: Subsequent observation care per day, high level. Physicians typically spend 35 minutes at the bedside and on the patient’s hospital floor or unit.

The above-listed codes have “B” status indicators and therefore are not billable to Medicare under OPPS. The definition of a status B code is: “Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x, 13x, and 14x).” Medicare further states, “An alternate code that is recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x, 13x, and 14x) may be available.” OPPS-based hospitals should elect to bill G0378 and G0379 for observation services.

As outlined in the Medicare Claims Processing Manual, Chapter 12, section 30.6.15.1 (www.cms.gov/manuals/downloads/clm104c12.pdf), CPT code 99354 (prolonged physician services in the office or other outpatient setting with direct face-to-face patient contact) can be used when the patient encounter requires one hour beyond the usual service when billed on the same day by the same physician or qualified nonphysician practitioner as the companion E/M codes. The time for usual service refers to the typical/average time units associated with the companion E/M service as noted in the CPT code.

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, Inc.
Plantation, FL

**Glenn Krauss, RHIA, CCS, CCS-P, CPUR**
*Independent HIM Consultant*
Madison, WI

**Laurette Pitman, RN, CCS, CPC-H, CGIC**
*Senior Auditor*
Health Information Partners
Newport Beach, CA

**Denise Williams, RN, CPC-H**
*Director of Revenue Integrity Services*
Health Revenue Assurance Associates, Inc.
Plantation, FL
Coding Q&A  < continued from p. 11

Each additional 30 minutes of direct face-to-face patient contact following the first hour of prolonged services may be reported by CPT code 99355.

With this in mind, CPT code 99354 (office or other outpatient prolonged service) can be used with codes 99224–99226 (subsequent observation) when the direct face-to-face patient contact time totals one hour and 15 minutes for 99224; one hour and 25 minutes for 99225; and one hour and 35 minutes for 99226.

The typical patient encounter times for the subsequent observation codes are identical to the times associated with subsequent inpatient hospitalization codes 99231–99233. Given the time requirement of one hour beyond the typical time for the main E/M level code billed, does the complexity of the patient’s clinical condition or conditions that require the physician’s prolonged face-to-face time warrant the billing of inpatient hospitalization codes?

Accounting for charges with new CPT codes

Q I’ve been working through the new 2011 CPT codes. What do I need to do to be sure that all the charges/costs are accounted for under the new codes?

A The AMA has issued some new “all-inclusive” and combination codes for several tests, procedures, and services for CY 2011. When making changes to the chargemaster, be sure to capture all the costs/charges from the individual deleted codes and include them in the line item for the new code.

For example, during 2010, a left heart catheterization was reported with individual codes to represent the catheterization, the injection procedure, and the imaging supervision/interpretation. For CY 2011, these have been combined into a single code to report the same services. When you set up the new line item for the comprehensive procedure, be sure that the charge on the single line item reflects the same cost/charge information as the individual line items previously did.

CMS uses the individual hospital’s charge information to determine the cost of a procedure/service. Just because the codes change doesn’t mean the cost to the facility changes. You want to be sure that the charges reported reflect the full cost of the procedure; otherwise, payment rates could be negatively affected when CMS uses the claims data from 2011 to set payment rates for 2013.

Other areas that are affected by this type of coding change and require specific detailed review are interventional radiology procedures, the new CT of abdomen and pelvis combination code, and drugs reported with HCPCS codes. Take the time to review each of these situations carefully.

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