Decision tree helps guide appropriate use of modifier -59

Dr. Cooper attempts to repair a rotator cuff tear using an arthroscopic approach, but she is unable to complete the repair. She then converts the procedure to an open repair. Should the coder report both procedures and append modifier -59 (distinct procedural service) to the CPT code for the arthroscopic repair?

According to the NCCI edits, if an arthroscopic procedure fails and the physician converts it to an open procedure, coders may only report the open procedure, says Susan E. Garrison, CHCA, CHC, CCS-P, CPC, CPC-H, PCS, FCS, CPAR, executive vice president of Healthcare Consulting Services at Magnus Confidential in Atlanta.

CMS developed the NCCI edits to prevent inappropriate payment of services that should not be billed by the same provider for the same patient on the same date of service.

The NCCI edits consist of two tables:

- Column one/column two correct coding edit table
- Mutually exclusive edit table

Each edit table contains pairs of HCPCS codes that providers should not report together. Each edit has a Column One and Column Two HCPCS code. When a provider reports both codes of an edit pair, the payer will deny the Column Two code and pay for the Column One code.

Of course, some exceptions exist, and that’s where the correct use of modifier -59 comes into play. Coders use modifier -59 to identify instances in which overriding an NCCI edit is appropriate because of certain circumstances. Those circumstances include:

- Different session or patient encounter
- Different procedure or surgery
- Different site or organ system
- Separate incision/excision
- Separate lesion
- Separate injury (or area of injury in extensive injuries)

Modifier -59 decision tree

Coders can use a decision tree to make sure they append modifier -59 appropriately.

First, determine whether the codes bundle together based on CPT or NCCI guidelines. Check the NCCI edits carefully using computer software, the Medicare website, or Medicare manuals, says Sarah L. Goodman, MBA, CHCAF, CPC-H, CCP, FCS, president/CEO and
principal consultant for SLG, Inc., of Raleigh, NC. If the codes bundle together, code both without unbundling modifier. If they do not, move on to the next question.

Second, ask whether the procedure was distinct from other procedures (different site, session, patient, diagnosis, etc.). If no, only bill the primary service and not the bundled code. If yes, move on to the next question.

Third, determine whether the NCCI edit has a modifier indicator of 0. A 0 indicator means that the edit can never be bypassed regardless of what modifier a coder uses, Goodman says. If the edit has a 0 indicator, do not use modifier -59 and do not bill separately. If it doesn’t have this indicator, move on to the next question.

Finally, decide whether there is a better, more specific modifier than modifier -59. Other modifiers include -LT and -RT, which designate specific sides of the body, and the digit modifiers (-T1, -T2, etc.). If there is a more specific modifier that can be used, use that modifier to separately bill. If not, use modifier -59 to separately bill.

Remember, do not append modifier -59 simply to bypass an edit and receive payment, Goodman says.

** Appropriately bypassing edits **

If the code pair is subject to an NCCI edit, the coder must determine how to bypass it when appropriate. Read the introduction and section-specific guidelines in the NCCI tables to determine the reason for the edit. Based on those guidelines, review documentation to determine whether the patient’s specific case falls under the guidelines.

In some cases, a code pair may not be subject to an NCCI edit, but a CPT guideline may prevent coders from reporting both codes. Goodman says coders need to do the following:

- Understand separate procedure designations
- Review CPT Assistant guidelines
- Review CPT Manual guidelines
- Refer to the NCCI Tools manual

Based on the CPT guidelines, review the documentation to determine whether the patient’s specific case falls under the guidelines, Goodman says.

**Coding multiple lesions, multiple locations **

Jane comes into the outpatient setting with benign lesions on her face, hand, and back. Dr. Baker biopsies the lesion on Jane’s hand, then biopsies and removes the lesions on her back and face. How should coders code these procedures?

For the hand lesion, code the biopsy (CPT 11100) since that is all Dr. Baker performed. For the face and back lesions, code only the removal of these lesions because the biopsy is a natural part of the removal, says Garrison.
The NCCI guidelines specify that if a biopsy is performed on a separate lesion, it is separately reportable. That’s why coders can report the hand biopsy, Garrison explains.

The NCCI edits further state:

*If a biopsy is performed and submitted for pathologic evaluation that will be completed after the more extensive procedure is performed, the biopsy is not separately reportable with the more extensive procedure.*

In this scenario, the above passage covers the situation of the back and face lesions, says Garrison. A more extensive procedure (the excision) is being performed, for which the biopsy is integral.

Coders may need to append modifier -59 to the hand biopsy because that procedure appears on the same claim as the removal of the back and face lesions, Garrison adds. The biopsy code is not anatomically specific, so the coder may need to append modifier -59 to let the payer know that the sites are different. “Watch for that carefully,” Garrison says. “If you need to append modifier -59 to keep it from being bundled erroneously, do so.”

Changing the situation slightly results in a different coding scenario. Imagine that Dr. Baker biopsies a lesion on Jane’s arm and is awaiting the biopsy results to determine what to do next—in other words, Dr. Baker will decide how to treat the lesion after receiving the pathology results. In this situation, coders should report the biopsy, Garrison says.

Another clear example of this difference is a breast mass. The physician performs a breast biopsy and is awaiting the results to determine whether to perform a lumpectomy, a mastectomy, or another procedure. Code both the biopsy and the more extensive procedure. Append modifier -58 (staged procedure) to the more extensive procedure so the payer knows the physician based the surgery decision on the biopsy results, Garrison says.

**Coding mutually exclusive codes**

Consider this situation: A physician performs the following two nerve conduction tests on a patient:

- 95900 (nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study)
- 95903 (nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study)

The two codes are mutually exclusive, so coders cannot report them together if they are performed on the same nerve, Goodman says. However, if the physician clearly documents that he or she performed the tests on different nerves or during different encounters on the same day, coders may report code 95900 with modifier -59.

“Hopefully the documentation is specific about which nerve was involved,” Goodman says. “If not, you may need to work with the provider to make sure that everything is documented appropriately.”

**Debridements—one site or two?**

Here’s another example to consider: A physician debrides 8 square centimeters of subcutaneous tissue of the patient’s left forearm (CPT code 11042) and 10 square centimeters of the dermis of the right shoulder (code 97597). This patient has wounds in two separate and distinct sites, and each wound is of a different depth. Since the documentation distinctly supports different wound depths, report code 97597 with modifier -59, Goodman says.

However, if the wounds were of the same depth—for instance, both were debridements of the dermis—then the coder would add the sizes together and report only 97597 since the total wound size would be less than 20 square centimeters.
Review documentation for correct hysteroscopy coding

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

A hysteroscopy is not the same as a hysterectomy. The two words sound similar but refer to two very different clinical procedures. A hysteroscopy is an inspection of the uterine cavity using a visual instrument (scope), while a hysterectomy is the surgical removal of the uterus. Physicians use both procedures to diagnose and treat uterine symptoms and disease.

Hysteroscopic procedures have their own set of CPT codes (58555–58565) listed just before the laparoscopic procedures in the CPT Manual.

Coding for hysteroscopy requires an understanding of the hysteroscopic procedure, the CPT code definition, and the ICD-9-CM diagnosis codes. Coder diligence in choosing procedure and diagnosis codes will ensure correct billing of claims to the insurance carrier or third-party payers.

Physicians use the hysteroscopic technique (aka uteroscopy) to look inside the uterus. With this procedure, the physician can make a decision regarding treatment options based on direct diagnostic visualization and/or biopsy of the uterus. The hysteroscope is a small lighted telescopic device that is placed inside the uterus via entrance through the vagina and cervix. This scope can also accommodate different tools that enable physicians to diagnose and surgically treat symptoms and diseases of the uterus.

Diagnosis testing using a hysteroscope

Using a hysteroscope, a physician can perform the following diagnostic tests and procedures:

- Uterine biopsy
- Uterine ablation
- Lysis of adhesions within the uterus
- Uterine dilatation and curettage (D&C)
- Removal or destruction of endometrial polyps
- Removal or destruction of endometrial tumors

Hysteroscopy operative report #1

➤ Preoperative diagnosis: Hypermenorrhea.
➤ Postoperative diagnosis: 1) Hypermenorrhea.

2) Secondary anemia.

➤ Procedure performed: 1) Dilatation and curettage.

2) Hysteroscopy.

➤ Gross findings: Uterus was anteverted, greatly enlarged, irregular, and firm. The cervix was patulous and nuliparous without lesions. Adnexal examination was negative for masses.

➤ Procedure: The patient was taken to the OR, where she was properly prepped and draped in sterile manner under general anesthesia. After bimanual examination, the cervix was exposed with a weighted vaginal speculum and the anterior lip of the cervix grasped with a tenaculum. The uterus was sounded to a depth of 11 centimeters. The endocervical canal was then progressively dilated. The hysteroscope was introduced into the uterine cavity using sterile saline solution as a distending medium and with attached video camera. The endometrial cavity was distended, then visualized. A moderate amount of proliferative endometriosis was noted. There were no direct intraluminal lesions seen. The patient tolerated the procedure well. Several pictures were taken of the endometrial cavity, and the hysteroscope was removed from the cavity.

A large sharp curet was used to obtain a moderate amount of tissue, which was then sent to pathology for analysis. The instruments were removed and accounted for. The patient was sent to recovery in satisfactory postop condition.

➤ Coding: CPT code: 58558. ICD-9-CM codes: 617.0 (endometriosis of uterus), 626.2 (hypermenorrhea), 285.9 (secondary anemia).
Introduction or removal of foreign bodies within the uterus (i.e., intrauterine devices [IUD])

Sterilization procedures

When using the hysteroscope, the physician inflates the uterus with gas or fluid so he or she can get a better view of the entire uterine cavity. This gas or fluid is commonly referred to in the operative or procedure record as the “distending medium.”

A hysteroscopy normally takes approximately 30 minutes to perform in either a physician’s office or a hospital outpatient department. When a physician performs a hysteroscopy in the hospital outpatient setting, he or she may use conscious sedation or general anesthesia.

Inclusive procedures

The following procedures are always included or bundled with hysteroscopic procedures, so don’t code them separately:

- Examination under anesthesia, which includes visualization of the vagina and cervix
- Bladder catheterization
- Application of a tenaculum and dilation of the cervix or cervical canal
- Insertion of the hysteroscope and distending media such as gas or fluid
- Inspection of the uterine cavity
- Injection or placement of local anesthesia, conscious sedation, or application of a nerve block used for anesthesia
- Removal of instruments, catheters, or drains
- Photo and operative report documentation

Coding for hysteroscopic procedures

In the CPT Manual, a diagnostic hysteroscopy (code 58555) is described as a detailed viewing of the uterus to diagnose either a symptom or disease of the uterus. The diagnostic hysteroscopy procedure is bundled with CPT codes 58558–58563. Code 58555 is a very straightforward code, encompassing only a diagnostic viewing of the uterus.

The verbiage in the next listed hysteroscopy CPT code can be confusing. CPT code 58558 is listed as a diagnostic viewpoint of the uterus.

Hysteroscopy operative report #2

- Preoperative diagnosis: Desires permanent sterilization.
- Operative procedure: Hysteroscopy with tubal occlusion.
- Anesthesia: General with para-cervical block.
- Estimated blood loss: Minimal.
- Complications: None.
- Pathology: None.
- Disposition: Stable to recovery room.
- Procedure: The patient was taken to the OR, where general anesthesia was found to be adequate. She was prepped and draped in the usual sterile fashion. A speculum was placed into the vagina. The anterior lip of the cervix was grasped with a single-tooth tenaculum and a para-cervical block was performed using 20 milliliters of 0.50% lidocaine with 1:200,000 of epinephrine.

The cervical vaginal junction at the 4 o’clock position was injected and 5 milliliters was instilled. The block was performed at 8 o’clock as well with 5 milliliters at 10 and 2 o’clock. Lidocaine was injected into the cervix. The cervix was minimally dilated. The 5-millimeter 30° hystroscope was then inserted under direct visualization using the lactated ringers as a distention medium. The uterine cavity was viewed, and a tubal occlusion device was then inserted through the operative port. The tip of the occlusive device easily slid into the right ostium of the fallopian tube. The coil was advanced and easily placed. The device was withdrawn. There were three coils protruding into the uterine cavity after removal of the insertion device. The insertion device was removed and reloaded. The procedure was then repeated with the same results on the left tube. Again, there were three coils protruding into the uterine cavity. The patient was then awakened, transferred, and taken to the recovery room in satisfactory condition.

Hysteroscopy coding  < continued from p. 5

hysteroscopy that includes a sampling (biopsy) of the endometrium and/or a polypectomy. The code description also states with or without D&C of the uterus.

Coder must carefully review what the definition of code 58558 states. The confusion comes, in part, because the CPT descriptor refers to “and/or polypectomy” in addition to “with or without a D&C.” Many coders make the mistake of billing a separate D&C or a separate polypectomy.

The CMS NCCI edits bundle many of the hysteroscopy codes together. Coders should not unbundle these codes. Make sure you carefully check the most current NCCI edits.

The next four hysteroscopy codes listed in CPT (58559–58562) include very specific descriptions. Physicians need to document a directed diagnosis reference for coders to report these codes. When coding for these four hysteroscopy procedures, coders must be sure the diagnosis corresponds correctly to the CPT code. In addition, coders should review the pathology report and operative documentation when choosing the diagnosis code.

Coders often confuse CPT code 58563 (hysteroscopy with endometrial ablation) with CPT code 58353 (endometrial ablation, thermal, without hysteroscopic guidance). Coders need to be diligent and carefully review the physician’s documentation to determine

Hysteroscopy operative report #3

➤ Preoperative diagnosis: Dysfunctional uterine bleeding refractory to medical therapy.

➤ Operative procedures: 1) Diagnostic hysteroscopy. 2) Dilation and curettage. 3) NovaSure uterine ablation.

➤ Anesthesia: General via ET tube.

➤ Findings: Endometrial lining was thin and normal in appearance. There were no polyps or fibroids. At the end of the ablation cycle, there was an excellent ablation throughout the entire endometrial lining.

➤ Complications: None.

➤ Condition: Hemodynamically stable.

➤ Procedure: Risks, benefits, and alternatives were reviewed with the patient. Informed consent was signed. The patient was taken to the OR, where general anesthesia was induced without difficulty. The patient was placed in the high lithotomy position using Allen stirrups and prepped and draped in the usual sterile fashion. Her bladder was drained with a red rubber catheter. A weighted speculum was placed in the vagina, and the anterior lip of her cervix was grasped with a single-tooth tenaculum. Her cervix was then sequentially dilated using dilators. Her uterus was slightly retroverted. The uterus was sounded to 8.5 centimeters. The cervical length was 3 centimeters, giving a cavity length of 5.5 centimeters.

The hysteroscope was passed through the patient’s cervix after a dilation of 8 millimeters was achieved with the dilators. The entire endometrial lining was visualized and was found to be fairly normal in appearance. The hysteroscope was removed, and a gentle curettage was carried out using a small curet. The hysteroscope was replaced, and an intact cavity was noted. The hysteroscope was removed and the NovaSure device was then advanced through her cervical os and opened. The cavity width was noted to be 3 centimeters. The device was enabled on the first two attempts.

A safety check was carried out and was found to be appropriate. The device was enabled, and the ablation cycle was carried out for just over a minute. At the end of the ablation cycle, the NovaSure device was removed. The hysteroscope was replaced, and an excellent ablation was noted throughout the entire endometrial cavity. The hysteroscope was removed. Cautery was used at her cervix at the tenaculum site for excellent hemostasis. Estimated blood loss was 50 cc. At the end of the procedure, sponge, lap, and needle counts were correct, and the patient was taken to the PACU extubated in excellent condition.

whether he or she used the hysteroscope during the procedure.

Code 58563 can also be used when the physician performs an endometrial resection. Documentation for this procedure is noted in the operative record by the usage of the resectoscope tool. Diagnoses such as endometriosis, excessive menstruation, or abnormal uterine bleeding can be treated with the resectoscope.

The last code in the hysteroscopy section of CPT is code 58565, which refers to a surgical hysteroscopy with bilateral fallopian tube cannulation to induce occlusion by placement of permanent implants. This procedure induces reproductive sterilization without cautery or incision of the fallopian tube. The physician uses the hysteroscope to place small implants into each of the fallopian tubes where the tube and the uterus meet.

The implants help create scar tissue buildup within the fallopian tube and block entrance of the egg to the uterus. Code 58565 specifically states that this procedure is a bilateral procedure, so remember not to append modifier -50 (bilateral procedure). However, if the physician performs the procedure unilaterally, append modifier -52 (reduced services).

ICD-10-CM prep: Determine documentation trouble spots

Each facility faces different challenges as it prepares for the transition to ICD-10-CM based on its size, location, and staff experience. Because no two organizations are exactly alike, each facility will also need to determine where its providers don’t adequately document.

Before coders start assessing ICD-10-CM documentation requirements and codes, they need to make sure they understand the ICD-9-CM guidelines. “If you don’t already know and love the ICD-9 guidelines, I recommend you become familiar with them,” says Kim Reid, CPC, CPC-I, CEMC, CMPA, Northeast regional director for the American Academy of Professional Coders. “Some of the guidelines have stayed the same, but it’s very important to become familiar with them to be aware of changes.”

Coders who understand the ICD-9-CM guidelines can compare ICD-9-CM’s requirements to ICD-10-CM’s requirements to identify where physicians don’t provide enough information.

Trauma centers are a good place to start evaluating physician documentation, says Donna Smith, RHIT, AHIMA-approved ICD-10 trainer and senior consultant for 3M Health Information Systems. Ask whether the physician is already documenting the level of specificity necessary. For example, the ICD-9-CM codes used to report a spinal cord injury in the neck include a range of several vertebrae. In ICD-10-CM, the codes specify the exact vertebra. For injuries to the internal organs, physicians will need to document the size and depth of the injury. If physicians aren’t already providing this detailed information, now is the time to get them started, Smith says.

However, not everything will require significant additional documentation. For example, the only change for pressure ulcer coding is the addition of laterality to the codes. Physicians should be documenting that information now, but if they aren’t, start querying them, Smith says.

ICD-10-CM does contain a code for pressure ulcer of unspecified hip, but it’s probably not a good idea to use it often. “Overutilization of this code will raise a red flag and increase the risk of an audit,” Reid says.

Consider some of the following areas when evaluating your providers’ documentation.

Diabetes coding

Currently, coders can choose between 59 combination codes (249–250) in ICD-9-CM to report diabetes.

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In ICD-10-CM, coders will have more than 200 codes available to report diabetes. The combination codes also include complications. Six categories exist for diabetes mellitus in ICD-10-CM:

➤ E08 (diabetes mellitus due to underlying condition)
➤ E09 (drug or chemical induced diabetes mellitus)
➤ E10 (type 1 diabetes mellitus)
➤ E11 (type 2 diabetes mellitus)
➤ E13 (other specified diabetes mellitus)
➤ E15 (unspecified diabetes mellitus)

Diabetes documentation and coding will need to include:

➤ Type or cause of diabetes:
  – Type 1
  – Type 2
  – Due to drugs or chemicals
  – Due to underlying condition
  – Other specified diabetes

➤ Body system complications related to diabetes, such as kidney or neurological complications

➤ Specific complications, such as:
  – Chronic kidney disease
  – Foot ulcer
  – Hypoglycemia without coma

Currently, when a coder queries a physician about a patient’s diabetes, the coder is probably using a preformatted query geared toward documentation requirements for ICD-9-CM, Smith says. She recommends changing the query forms now to get physicians used to the additional information they will need to document for ICD-10-CM.

Another change to diabetes coding is that the physician will no longer need to state whether the diabetes is controlled or uncontrolled, Reid says.

Injury coding

In ICD-10-CM, coders will report a separate code for each injury, which is a change from ICD-9-CM, says Smith. Coders will add the appropriate seventh character to denote an initial visit (A), subsequent visit (D), or sequela (S).

Currently in ICD-9, coders report aftercare codes for injuries, but in ICD-10-CM, they will code the actual injury with the appropriate seventh character, Smith says.

ICD-10-CM also contains different codes for aftercare and follow-up care, Reid says. With aftercare, providers are generally managing a condition. In follow-up care they are generally maintaining surveillance of an injury.

Providers need to document both laterality and specificity for every injury. ICD-10-CM still contains unspecified codes, but coders should be wary of using them, Reid says. “It seems funny to have unspecified codes with the increase in specificity,” she notes.

For example, a provider documents that the patient had an ankle sprain, but the coder can’t tell which ankle was sprained. If that detail isn’t in the documentation,
coders need to query the physician and make sure the coders have the information correct.

**ENT coding**

ICD-10-CM adds specific chapters of codes for eyes/adnexa and ears. Is the physician documenting which ear he or she examined during an ear, nose, and throat visit?

Consider this scenario: A patient comes in with an earache. The provider performs a problem-focused history and exam and documents otitis media, amoxicillin twice daily x 10 days, with follow-up in one week if no improvement.

In ICD-9-CM, coders would assign code 382.9 (otitis media, unspecified). However, ICD-10-CM contains a large number of options for this diagnosis, and the documentation should include the necessary information, Reid says. In ICD-10-CM, coders will choose between right ear, left ear, bilateral, and unspecified when it comes to coding unspecified otitis media.

Be very careful about using H66.90 (otitis media, unspecified), Reid cautions. “The physician examined the patient; how can they not know what ear the otitis media is in?” she says. “In ICD-10-CM we have codes for laterality, so we shouldn’t be using unspecified codes.”

Insurance companies may question the integrity of a claim that is submitted stating “unspecified ear” because such vital information should be indicated in the documentation, Reid adds.

**Musculoskeletal coding**

Conditions of the musculoskeletal system, such as osteoarthritis, gout, rheumatoid arthritis, and osteonecrosis, all need specificity of exact site and laterality in ICD-10-CM. If the patient has a history of a certain condition, coders may decide not to query the physician for site and laterality because it won’t change the coding. If the condition is the reason for the patient’s visit, the physician needs to document that information.

In addition, the physician needs to link the condition to a disease process. For example, the physician should document gout due to renal impairment or drug-induced gout, says Smith.

**Pathologic fracture coding**

A pathologic fracture is a broken bone caused by disease, and ICD-10-CM expands the code selection for these types of fractures to more than 150 codes. In ICD-9-CM, coders can select between only eight codes.

Pathologic fracture documentation and coding will need to include:

- Exact location of fracture
  - Site
  - Laterality
- Etiology of fracture
  - Osteoporosis
  - Neoplastic disease
- Encounter type
  - Initial encounter
  - Subsequent encounter
  - Subsequent encounter with delayed healing

If a patient has osteoporosis and a fracture without a fall, the fracture is often assumed to be pathologic, Smith says.

**Physician training**

Even though the conversion to ICD-10-CM seems a long way off, start getting physicians acquainted with the increased documentation requirements now, Smith says. Bring actual examples to the physicians to help them understand the current state of their documentation and what needs to change for ICD-10-CM.

Look at the top 10 areas problem areas at your facility and determine where your physicians need the most education. “Start now so over the next two years you can get the physicians up to speed,” Smith says.

Also look at your query forms. If you have preformatted forms, tweak them to include ICD-10-CM language, Smith says. Coders will still be able to code the encounter in ICD-9-CM, but they and the physicians will start to see what additional information is needed in ICD-10-CM.
Local anesthetic used for wound care

**Q** If the physician uses lidocaine gel to numb a diabetic foot ulcer and remove a callus from around it, can we charge 97597: removal of devitalized tissue from wound(s), selective debridement without anesthesia (e.g., high pressure waterjet with/without suction, sharp debridement with scissors, scalpel and forceps), with/without use of whirlpool, topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 20 square centimeters?

**A** Local numbing of an area in preparation for the service/procedure is included in the service. The description you have given sounds like topical anesthesia. The removal of a callus around an ulcer and not ulcerative tissue or components would be assigned a CPT code from the removal/excision callus indexing. You also need the specific size of the ulcer. Check your CPT Manual carefully.

Copays for preventive services

**Q** How does healthcare reform affect copayments for preventive services?

**A** In March 2010, President Obama signed two acts with significant importance. The Patient Protection and Affordable Care Act, Public Law 111-148 (signed March 23), and the Health Care and Education Reconciliation Act of 2010, Public Law 111-152 (signed March 30), attempt to change the nature and culture of modern healthcare. These two acts are collectively known as the Affordable Care Act (ACA).

The ACA broadens Medicare coverage for preventive services. The ACA requires that Medicare pay 100% for preventive services recommended by the United States Preventive Services Task Force (USPSTF) with a grade of A or B when those services are appropriate for the individual.

These provisions waive any deductible or coinsurance for the wellness visits and most of the preventive items and services (e.g., bone mass measurements, colorectal cancer screening, influenza and pneumococcal vaccines, and ultrasound abdominal aortic aneurysm screening).

The USPSTF updated the definitions of its grades to include recommendations and suggestions for practice associated with each grade. The USPSTF has also defined levels of certainty regarding net benefit. These definitions, shown below, apply to USPSTF recommendations voted on after May 2007:

- **A**: The USPSTF recommends the service. There is high certainty that the net benefit is substantial.

Suggestion: Offer or provide this service.

**Contributors**

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

- **Gloryanne Bryant, RHIA, CCS, CCDS**
  Regional Managing Director HIM, NCAL Revenue Cycle
  Kaiser Foundation Health Plan, Inc. & Hospitals
  Oakland, CA

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

- **Joanne M. Becker, RHIT, CCS, CCS-P, CPC, CPCI**
  Associate Director, Joint Office for Compliance
  The University of Iowa Hospitals and Clinics
  Iowa City, IA

- **Caral Edelberg, CPC, CPMA, CAC, CCS-P, CHC**
  President
  Edelberg Compliance Associates
  Baton Rouge, LA
➤ **B:** The USPSTF recommends the service. There is high certainty that the net benefit is moderate, or there is moderate certainty that the net benefit is moderate to substantial. Suggestion: Offer or provide this service.

➤ **C:** The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is at least moderate certainty that the net benefit is small. Suggestion: Offer or provide this service only if other considerations support the offering or provision of the service in an individual patient.

➤ **D:** The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits. Suggestion: Discourage the use of this service.

➤ **I:** The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined. Suggestion: Read the clinical considerations section of the USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.

Some of the preventive services do not meet the criteria for the waiver of the deductible and coinsurance. The following preventive services continue to be subject to the deductible and coinsurance as there is no statutory provision that exempts them:

> Digital rectal examination furnished as a prostate cancer screening service (HCPCS Level II code G0102)
> Glaucoma screening (HCPCS Level II codes G0117 and G0118)
> Diabetes outpatient self-management training services
> Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination (HCPCS Level II code G0404)

### Billing for ED “boarders”

**Q** Is there a compliant reimbursement path for psychiatric patients who have not been admitted as inpatients, yet remain as ED boarders waiting for an inpatient psychiatric bed? May we charge an established outpatient visit for documented care provided each day? Do you have any special documentation recommendations to meet medico-legal standards of care for these patients?

**A** Unfortunately, boarding isn’t a billable service outside of either medically necessary observation services or the ED visit levels. CMS has been very clear about this in the past. If it is not medically necessary that the patient receive ED treatment and he or she is being housed in the ED for administrative and not clinical purposes, CMS will not pay for the boarding service. Once the patient is formally admitted, he or she ceases to be an outpatient and transitions to inpatient status. The emergency physician has transferred care to the admitting physician, who is responsible for the care. If the patient is not admitted but remains in the ED, there is no visit code applicable. You might want to check with your local Medicare carrier.

You may want to review the medico-legal standards at [www.ACEP.org](http://www.ACEP.org) for information on ED boarding and the legal implications.

### Observation and hydration

**Q** We have been trying to decipher the available information regarding patients placed in our observation unit who receive hydration during their course of care. If we pull out the hydration time, can we bill for observation hours pre- and post-infusion?

**A** The key to whether you should carve out the hydration time comes down to active monitoring. Not all services require active monitoring. CMS states, “The hospital must determine if active monitoring is a

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part of all or a portion of the time for the particular drug administration services.”

Whether active monitoring is part of the drug administration service may depend on the type of drug administration service furnished, the specific drug, or the needs of the patient. For example, a complex drug infusion titration to achieve a specified therapeutic response that is reported with HCPCS codes for a therapeutic infusion may require constant active monitoring by hospital staff. On the other hand, the routine infusion of an antibiotic, which may be reported with the same HCPCS codes for a therapeutic infusion, may not require significant active monitoring.

In most cases, hydration would not require active monitoring and therefore would not be carved out of the observation service.

Hydration provided during observation

Q We are wondering what to charge when a patient needs hydration the whole time he or she is in observation. We understand that we need to stop and start hydration time when a patient has an infusion of another kind; does this also apply to for blood transfusions? Do we have to deduct observation time when giving IV pushes? If so, what amount of time do we deduct from observation?

A Refer to the Q&A published on the CMS website (http://questions.cms.hhs.gov).

The question comes down to what is determined to be active monitoring. CMS says that procedures that require active monitoring should not be billed concurrently with observation services.

The hospital must determine whether active monitoring is sometimes or always associated with a drug administration service. For example, chemotherapy requires active monitoring. I do not believe simple hydration fits that definition, nor would most routine drug administrations. In fact, CMS notes that the routine infusion of an antibiotic and certain other therapeutic infusions do not require active monitoring. Thus, not all infusions need to be carved out. Active monitoring refers to those instances where there is constant attendance by a healthcare professional and/or more frequent monitoring of vitals during the administration of the drug.

To answer the question regarding hydration, the hydration hours should not be carved out of the observation hours. I don’t believe you will be carving out time for most pushes either. Blood transfusions may need some active monitoring since they require the nurse to take periodic vital signs and also assess the patient for a reaction at greater intervals than just standard infusions and/or injections.