Ensure accurate reporting and coding of critical care

When the AMA revised the instructions for reporting ancillary services with critical care in 2011, facilities knew they wouldn’t see an immediate increase in payment. CMS determines payment amounts through use of claims data from two years earlier, meaning the earliest facilities could expect additional reimbursement is 2013.

However, when CMS reviewed the 2011 claims data, it found no change in the costs/charges related to CPT® codes 99291 (critical care, evaluation and management of the critically ill or critically injured patient; first 30–74 minutes) and 99292 (critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes). The claims also failed to show a significant increase in the ancillary services reported on these claims.

As a result, CMS will not change its payment methodology for critical care services for 2013. CMS plans to continue its policy of packaging payment for ancillary services reported on the same date of service into CPT code 99291, noting that providing separate payment would actually result in overpayment.

Changes to critical care reporting

Critical care is defined as the direct delivery of medical care by a physician or provider to a critically ill or injured patient.

Typically, one or more vital organs or organ systems are impaired, and the patient’s condition has a high probability of immediate deterioration. In addition, if critical services are not immediately rendered, the patient faces a high probability of death.

The change in the guidelines created significant problems for hospitals that previously trained coders to bundle ancillary services into the critical care code, says Caral Edelberg, CPC, CPMA, CAC, CCS-P, CHC.

The CPT Editorial 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 specified ancillary services. (For a list of these services, see p. 3.) Instead, the CPT guidelines instruct facilities to separately report ancillary services and associated charges provided in conjunction with critical care. CMS instructed hospitals to follow the CPT guidelines and report these services and associated charges separately.

The change in the guidelines created significant problems for hospitals that previously trained coders to bundle ancillary services into the critical care code, says Caral Edelberg, CPC, CPMA, CAC, CCS-P, CHC, president of Edelberg Compliance Associates of Baton Rouge, La.
However, CMS also noted in Transmittal 2141 that it would institute claims processing edits that would continue to package the payment for these services into the payment for the critical care visit (CPT 99291), says Denise Williams, RN, CPC-H, vice president of revenue integrity services at Health Revenue Assurance Associates, Inc., in Plantation, Fla.

When ancillary services are not provided in conjunction with critical care, CMS will separately reimburse for them, Edelberg says. Coders should append modifier -59 (distinct procedural service) to the codes for ancillary services provided during a separate episode of care.

“Payment for those services will not be conditionally packaged into the payment for critical care,” Edelberg says. Before CPT revised the reporting guidelines, payers often bundled all ancillary services in with the critical care payment, even if the services were not related to critical care. Coders can append modifier -59 to unbundle those services so the facility receives appropriate payment for services not related to critical care, Edelberg says.

### Reporting critical care

Critical care codes are time-based codes, so providers must document time not just for proper reporting, but also so the facility can bill for its part of the services.

Coders may struggle when it comes to counting critical care time for the facility. “This is a big, big question because it’s easier to look at the start and stop time for the entire episode of care for that critical patient,” Edelberg says. However, CMS has a very different definition of critical care time, she says. Under the OPPS, the time spent by a physician and/or hospital staff engaged in active face-to-face critical care of a critically ill or critically injured patient is what is counted.

If the physician and hospital staff are simultaneously engaged in this care, the time involved can only be counted once.

“It’s interesting that CMS, in talking about OPPS critical care, references time spent by the physician and the critical care staff,” Edelberg says. “So CMS is looking to count the time spent by all of the providers in the emergency department, but only once.”

As a result, if a physician and a nurse are both providing critical care during the same 30-minute time span, coders can only report a total of 30 minutes of critical care time, not 60 minutes (30 for the physician and 30 for the nurse).
Now consider a slightly different scenario: The nurse provides 15 minutes of critical care and leaves. The physician comes in and provides 15 minutes of critical care and leaves. The nurse then returns to provide an additional 15 minutes of care. In this case, coders would add the times together and report 45 minutes of critical care because none of the care overlapped.

On the physician coding side, coders don’t just count face-to-face time when reporting critical care. For physician reporting, critical care time includes any time the physician spent attending or providing services (directly or indirectly) to the patient.

“So it’s bedside time, it’s unit time, it’s any time the physician spends managing the patient or the patient’s condition,” Edelberg says. That includes reviewing diagnostic studies, interpreting tests, talking to the patient’s family, and giving orders to other providers. As a result, the time the facility can bill for critical care may differ significantly from the time the physician can bill for critical care, she adds.

Facilities need to create a process to capture critical care time for each provider in order to accurately bill for critical care services. The process should allow the facility to capture both incremental and continuous time as well as time for each individual provider. It should also offer a way to identify overlapping time when two or more providers are involved in critical care.

“It’s going to be very important if you are audited to show that your time has been counted very, very accurately,” Edelberg says.

CMS only pays for critical care if at least 30 minutes of critical care services are provided and documented. If the facility does not provide at least 30 minutes of critical care, coders should report a level 4 or 5 ED visit, depending on the facility’s E/M criteria.

“That’s why it’s so important for your [ED E/M] criteria to be acuity distributed,” Edelberg says. “If for some reason you don’t meet the critical care time, all of the resources that are part of critical care fall to a level 5 [E/M], not a level 4.”

More than one physician can provide critical care and be paid if the service meets the definition of critical care, is medically necessary, and is not duplicative, says Edelberg. In addition, coders should note that time does not need to be continuous in order to be counted.

### Reviewing claims with critical care

Each facility should review its current reporting practices for critical care (CPT 99291) and the ancillary services that were considered to be included prior to January 2011.

Coders and billers should report these services on a separate line item with a CPT code and charge to reflect the cost and the specific services provided to the individual patient.

“Facilities should review exactly what is being reported on the claim and coming back on the remittance advice,” Williams says. Some claim scrubbers require the removal of a service if coders don’t append a modifier, meaning the cost/charge is lost when the claim is finally submitted. If a facility is reporting the line item separately but without a modifier to indicate the service is separate and distinct from critical care, the line item should be allowed to pass through the scrubber edits.

### Separately reportable services

When reporting critical care, CPT guidelines now instruct facilities to separately report services, including:

- 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 (e.g., ECGs, blood pressures, hematologic data) (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)
ICD-10 anatomy refresher: Shoulder

Editor’s note: With the increased specificity required for ICD-10-CM coding, coders need a solid foundation in anatomy and physiology. To help coders prepare for the upcoming transition, we will provide an occasional article about specific anatomical locations and body parts as part of a larger series for ICD-10-CM preparation. This month’s column addresses the anatomy of the shoulder.

The shoulder girdle has the most varied and widest range of motion of any joint in the human body. That also makes it one of the most unstable. Three separate joints make up the shoulder girdle, and they are kept in place by a system of muscles, ligaments, and tendons.

Coders will need to look for documentation of specific muscles, ligaments, and tendons when coding for shoulder injuries in ICD-10-CM. In addition, they will need to know the different joints and bones associated with the shoulder.

Shoulder joints

A joint is formed when two or more bones meet. The human body contains three main types of joints: fibrous (immovable), cartilaginous (partially movable), and synovial (freely movable). Synovial joints are further divided into six different types:
➤ Hinge
➤ Pivot
➤ Ball and socket
➤ Saddle
➤ Condyloid
➤ Gliding

The shoulder girdle is made up of three distinct joints:
➤ The glenohumeral (GH) joint is a ball-and-socket joint where the humerus meets the glenoid on the scapula. This is the joint most people think of as the shoulder joint. The small round head of the humerus fits into the small, shallow glenoid fossa (socket) on the lateral side of the scapula. Ligaments, tendons, and anterior muscles hold the humerus in place.

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In ICD-10-CM, coders will report codes in the S43-series (dislocation and sprain of joints and ligaments of shoulder girdle) when a physician documents a subluxation or dislocation of the shoulder joint. These codes require seven characters, including a seventh character to denote the encounter (initial, subsequent, or sequela).

Subluxations and dislocations of the shoulder are classified by the bone or joint involved and are further specified by laterality. For a subluxation or dislocation of one of the shoulder joints, coders would choose among

![Figure 1](image-url)
these subcategories:
➤ $S43.0$, subluxation and dislocation of shoulder joint
➤ $S43.1$, subluxation and dislocation of acromioclavicular joint
➤ $S43.2$, subluxation and dislocation of sternoclavicular joint
➤ $S43.3$, subluxation and dislocation of other and unspecified parts of shoulder girdle

The codes for the specific joints are then further subdivided to include specific types of subluxations and dislocations, laterality, and encounter. For example, category $S43.1$ (subluxation and dislocation of acromioclavicular joint) is subdivided into the following categories:
➤ $S43.10$, unspecified dislocation of acromioclavicular joint
➤ $S43.11$, subluxation of acromioclavicular joint
➤ $S43.12$, dislocation of acromioclavicular joint, 100%–200% displacement
➤ $S43.13$, dislocation of acromioclavicular joint, greater than 200% displacement
➤ $S43.14$, inferior dislocation of acromioclavicular joint
➤ $S43.15$, posterior dislocation of acromioclavicular joint

Bones of the shoulder girdle

The bones of the shoulder girdle include the humerus, scapula, and clavicle.

The humerus is the upper arm bone. The head of the humerus is the ball within the ball-and-socket GH joint. Below the head are the greater and lesser tubercles, where the four rotator cuff muscles attach to the humerus.

The scapula, also called the shoulder blade, is a large triangular bone that floats on the rib cage and is anchored by muscles instead of a true joint. The spine, acromion, and coracoid processes serve as landmarks on the scapula. The acromion, a bony process on the scapula, forms the roof of the GH joint. It also forms the AC joint where it joins the clavicle. The spine divides the back of the scapula into two sections. The scapula forms the back portion of the shoulder girdle.

The clavicle begins at the sternum (breastbone) just above the first rib and is the only bony attachment between the trunk and the arm. The clavicle forms the front part of the shoulder girdle.

Codes for injuries to the bones of the shoulder require seven characters, and coders will select a code based on the specific injury. For example, if a patient suffers a dislocation of the humerus, coders have the following categories of codes to choose from:
➤ $S43.01$, anterior subluxation and dislocation of humerus
➤ $S43.02$, posterior subluxation and dislocation of humerus
➤ $S43.03$, inferior subluxation and dislocation of humerus

Each code requires a sixth character to denote laterality and a seventh character for the encounter. So if the physician documents an initial visit for a posterior subluxation of right humerus, coders would report $S43.021A$.

If a patient suffers a fractured scapula, coders need to know whether the fracture is displaced or non-displaced, as well as the specific site of the fracture. For a fracture of the scapula, coders would choose the appropriate code from the following:
➤ $S42.11$, fracture of body of scapula
➤ $S42.12$, fracture of acromial process
➤ $S42.13$, fracture of coracoid process
➤ $S42.14$, fracture of glenoid cavity of scapula
➤ $S42.15$, fracture of neck of scapula
➤ $S42.19$, fracture of other part of scapula

The sixth and seventh characters provide additional information. If the patient is seen for a subsequent visit for a displaced fracture of neck of scapula of the left shoulder, coders would report $S42.152D$.

Shoulder muscles

Muscles in the back, neck, shoulder, chest, and upper arm work together to move and support the shoulder. Those muscles include:
➤ **Anterior serratus**, which originates on the surface of the upper eight ribs at the side of the chest and inserts along the entire anterior length of the medial border of the scapula

➤ **Subclavius**, which originates on the first rib and penetrates the subclavian groove of the clavicle

➤ **Pectoralis minor**, which arises from the third, fourth, and fifth ribs near their cartilage and inserts into the medial border and upper surface of the coracoid process of the scapula

➤ **Sternocleidomastoid**, which attaches to the sternum (sterno-), the clavicle (cleido-), and the mastoid process of the temporal bone of the skull

➤ **Levator scapulae**, which is situated at the back and side of the neck and lifts the scapula

➤ **Rhomboid major and rhomboid minor**, which work together and arise from the spinous processes of the T1–T5 thoracic vertebrae and from the spinous processes of the seventh cervical vertebra

➤ **Trapezius**, which arises from the occipital bone, the ligamentum nuchae, the spinous processes of the seventh cervical vertebrae, and the spinous processes of all the thoracic vertebrae, and from the corresponding portion of the supraspinal ligament

➤ **Deltoid**, which forms the rounded contour of the shoulder and is also known as the common shoulder muscle

### Shoulder ligaments

The joint capsule is a watertight bag that surrounds the GH joint and prevents it from dislocating.

Four ligaments make up the joint capsule that connects the humerus to the glenoid:

➤ Superior glenohumeral

➤ Middle glenohumeral

➤ Inferior glenohumeral, which splits into a front and back half and acts like a sling to support the humerus

➤ Posterior glenohumeral

The superior, middle, and inferior glenohumeral ligaments are all located on the anterior side of the GH joint.

Three ligaments support the AC joint:

➤ Coracoacromial, which is a strong triangular band extending between the coracoid process and the acromion

➤ Coracoclavicular

➤ Acromioclavicular, which strengthens the fibrous capsule of the AC joint between the lateral end of the clavicle and the acromion of the scapula

In addition, the glenohumeral ligaments reinforce the front of the shoulder joint.

The coracohumeral ligament is a broad ligament that strengthens the upper part of the capsule of the shoulder joint.

Sprains to the ligaments are divided by laterality and specific ligament involved. For a sprain of right coraco-humeral (ligament), initial visit, report code S43.411A.
Rotator cuff

The rotator cuff is a group of tendons and muscles in the shoulder connecting the upper arm to the shoulder blade. The rotator cuff tendons provide stability to the GH joint, while the muscles allow the shoulder to rotate.

The muscles in the rotator cuff include:

- Teres minor
- Infraspinatus
- Supraspinatus
- Subscapularis

Each muscle of the rotator cuff inserts at the scapula and has a tendon that attaches to the humerus. Together, the tendons and other tissues form a cuff around the humerus.

ICD-10-CM includes a category of codes specifically for injuries to the rotator cuff (S46.0). These codes include:

- **S46.00**, unspecified injury of muscle(s) and tendon(s) of the rotator cuff of shoulder
- **S46.01**, strain of muscle(s) and tendon(s) of the rotator cuff of shoulder
- **S46.02**, laceration of muscle(s) and tendon(s) of the rotator cuff of shoulder
- **S46.09**, other injury of muscle(s) and tendon(s) of the rotator cuff of shoulder

These codes do not specify the muscle or tendon of the rotator cuff involved and do not differentiate between muscles and tendons. However, coders will need to add sixth and seventh characters to denote laterality and encounter.

Simplify chronic kidney disease outpatient coding

The kidneys filter wastes and excrete fluid when the blood is forced through their internal structures. However, various diseases, including chronic kidney disease (CKD), can affect how well the kidneys function.

CKD is a permanent alteration in the kidneys’ ability to perform filtration and reabsorption functions. Patients with CKD may be admitted as inpatients, either for the CKD or some other condition, but they may also come into an outpatient clinic. As such, outpatient coders need to be able to recognize the stages of CKD and understand what tests and procedures providers may perform in a clinic or other outpatient setting.

Documentation necessities

The patient’s medical record is key for proper billing, but it also keeps track of the patient’s care, says Debra Lawson, CPC, PCS, a consultant with Nephrology Billing & Management Services, LLC, of Rogersville, Tenn. In an audit, the medical record provides the only protection for the patient and the provider.

“You don’t see an auditor come in, put an arm around the physician, and ask, ‘What were you thinking when you treated this patient?’” Lawson says. If the provider doesn’t document well, the coder can’t assign the correct codes and can’t defend the coding during an audit, she adds.

ICD-9-CM CKD coding

Glomerular filtration rate (GFR) measures the creatinine level of the blood and how well the kidneys function. Physicians generally look at GFR during a patient’s annual physical, Lawson says. Kidneys that are not functioning optimally do not filter waste correctly, causing the creatinine level in the blood to rise.

Muscles generate creatinine as a waste product. Because people have different amounts of muscle, they produce different amounts of creatinine. GFR allows physicians to compare kidney function across the population because it accounts for age, race, and gender, factors that impact how much muscle someone has, Lawson says.

A patient with CKD progresses through as many as six stages, according to the National Kidney Foundation. Stage I CKD is a GFR greater than or equal to 90. “If you
look at the statistics, it is safe to say everyone has Stage I CKD, but a diagnosis is based on additional factors,” Lawson says.

Stage II CKD is a GFR of 60–90. This is mild kidney disease, says Lawson. At this stage, most people don’t even realize they have a problem.

A GFR of 30–59 is Stage III CKD, or moderate kidney disease. These patients may still be symptom free, Lawson says.

Stage IV CKD is a GFR of 15–29. This is severe kidney damage, and a physician will start preparing a patient at this stage for kidney replacement therapy, Lawson says.

A GFR of less than 15 is Stage V CKD and is considered kidney failure. Patients who have a GFR of less than 15 and are receiving dialysis have Stage VI CKD and are diagnosed with end-stage renal disease (ESRD), Lawson says. The difference between Stages V and VI is dialysis, she adds.

Coders will find the ICD-9-CM codes for CKD in the 585 series, says Jennifer E. Avery, CCS, CPC-H, CPC, CPC-I, senior regulatory specialist with HCPro, Inc., in Danvers, Mass. Coders need to choose the appropriate fourth digit to identify the stage of CKD, she adds.

If the physician does not document the stage of CKD, report code 585.9 (chronic kidney disease, unspecified), Avery says. If the provider documents both a stage of kidney disease and ESRD (585.6) in the record, code only 585.6, she adds.

**Signs and symptoms of CKD**

The kidneys not only filter fluids, they also filter toxins. As a result, a patient may experience changes in mental status when the kidneys start to fail, Lawson says.

Patients with CKD may also suffer from a sudden loss of the ability of the kidneys to remove waste and concentrate urine and/or excrete electrolytes. This abrupt loss of kidney function is called acute kidney failure (AKF) or acute kidney injury, Lawson says.

AKF and CKD are two separate and distinct conditions, Avery says. AKF has an abrupt onset and is potentially reversible. CKD progresses slowly over time and can lead to permanent kidney failure. If both AKF and CKD are clearly documented, code both conditions, she says.

Code the AKF as primary with ICD-9-CM code 584.9, followed by the stage of CKD prior to the exacerbation, Lawson adds.

**Testing for CKD**

The National Kidney Foundation recommends three tests for CKD:

- Blood pressure measurement
- Spot check for protein or albumin in the urine
- Calculation of GFR based on a serum creatinine measurement

High blood pressure can lead to CKD or be a symptom of existing kidney failure, Lawson says. A primary care physician unable to get the patient’s blood pressure under control may send the patient to a nephrologist, who can check to see whether the high blood pressure is underlying CKD.

Healthy kidneys take waste out of the blood but leave protein. Impaired kidneys may fail to separate a blood protein called albumin from the waste. At the start of kidney disease, small amounts of albumin may leak into the urine. This condition, known as microalbuminuria, is a sign of worsening kidney function, Lawson says.

As the kidneys deteriorate, the amount of albumin and other proteins in the urine increases. This condition is called proteinuria, and coders would report it with ICD-9-CM code 791.0.

In addition, a physician may order an ultrasound, CT scan, and/or MRI to find unusual growths or blockages to the flow of urine, Lawson says.

Finally, a physician may perform a kidney biopsy, especially if a kidney transplant starts to fail. Report a kidney biopsy with CPT code 50200. Remember that even though the physician usually takes three core samples for the biopsy, coders should report only one unit of 50200, Lawson says.
This Month’s Coding Q&A

Coding for hysteroscopy prior to ablation

Q When a woman has an endometrial ablation performed, our gynecologists routinely do a diagnostic hysteroscopy prior to the ablation to document normal endometrial contour, etc. When we report the CPT® codes for these procedures, would it be correct to choose the CPT procedure code WITHOUT hysteroscopic guidance? Example: Hysteroscopy is performed, normal findings are noted, and the hysteroscope is removed. The ThermaChoice® ablation unit is then assembled, inserted, and ablation performed. Should we report CPT 58353 (endometrial ablation, thermal, without hysteroscopic guidance) and 58555 (diagnostic hysteroscopy) with modifier -59 (distinct procedural service)?

A CPT states that diagnostic procedures are always bundled into a surgical procedure. I would query the coder/provider to verify that the diagnostic hysteroscopy (the scope itself) was only performed for the diagnostic portion of the case and that the ablation procedure was done “blind” (i.e., the ablation unit was not attached to the hysteroscope). Most frequently the hysteroscope has an attached ablation unit so the physician can fully visualize the endometrial cavity prior to the ablation.

If the procedures are truly “separately identifiable,” then the office could potentially bill both procedures with modifier -59, overriding the CCI edits. However, in my experience, I have not seen that the hysteroscope was only performed diagnostically, then a blind ablation performed after.

Appending modifier -59 for MRI and MRA

Q We have a stroke protocol that requires 70553 (MRI, brain including stem, without and with contrast) and 70544 (MRA, head, without contrast). These tests are performed at the same time in the same scanner and one report is created, but there are separate images for each procedure. Should I append modifier -59 (distinct procedural service) to code 70544?

A You would not append modifier -59 if the scans are performed at the same time. NCCI indicates: Magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA) procedures for the same anatomic location may be reported together in limited circumstances. If a single technical study is performed which is utilized to generate images for separate MRI and MRA reports, only one procedure, either the MRI or MRA, for the anatomic region may be reported. Both an MRI and MRA may be reported for the same anatomic region if they are performed at separate patient encounters or if two separate and distinct technical studies, one for the MRI and one for the MRA, are performed at the same patient encounter. The medical necessity for the latter situation is uncommon.

So, your circumstances do not support the modifier use. When the physicians also perform a neck MRI, you can report both with modifier -59 since it is a different region and code, as long as medical necessity supports it.

Charging for venipunctures

Q I am relatively new to auditing, and when I look at my facility’s claims I see the venipuncture code (CPT code 36415) assigned on some bills but not all of them. All these claims have laboratory services. Can you explain what I need to look for when I do not see the venipuncture code on the claim?

A CPT code 36415 (collection of venous blood by venipuncture) is used when facility personnel perform a blood draw for the purpose of laboratory testing.
CMS’ Claims Processing Manual, Chapter 16, states: A specimen collection fee is allowed in circumstances such as drawing a blood sample through venipuncture (i.e., inserting into a vein a needle with syringe or vacutainer to draw the specimen) or collecting a urine sample by catheterization. A specimen collection fee is not allowed for blood samples where the cost of collecting the specimen is minimal (such as a throat culture or a routine capillary puncture for clotting or bleeding time) … Only one collection fee is allowed for each type of specimen for each patient encounter, regardless of the number of specimens drawn. When a series of specimens is required to complete a single test (e.g., glucose tolerance test), the series is treated as a single encounter.

In some cases, the venipuncture is not charged because nursing personnel will draw blood during the start of an IV line. When the blood specimen is taken during the start of the IV line, the stick is included in the initial service for drug administration and CPT code 36415 is not reported additionally.

When the blood is drawn from a saline lock (for example, in the ED), some facilities choose to include this as part of the individual resource mapping criteria. Review your individual facility’s criteria to determine whether this is included in order to capture the resources involved.

**Therapy caps under OPPS**

**Q** Our outpatient rehabilitation services director is concerned about the therapy caps related to physical, occupational, and speech therapies. I keep telling him that hospitals are excluded under the OPPS, but he keeps arguing with me about it. Is there something new about these caps?

**A** Up until now, hospital outpatient therapy departments have been excluded from the therapy caps, but beginning October 1 this will no longer be the case. The therapy cap amounts for CY 2012 are $1,880 for occupational therapy and $1,880 for physical and speech therapy combined. The Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA), Section 3005, made several changes to the policy. For services provided from October 1, 2012, through January 1, 2013, the thresholds will increase to $3,700 for the year.
The act also requires that hospital outpatient therapy services for original Medicare be included in the amount subject to the cap as well as other related provisions. All therapy services provided by hospital outpatient therapy departments for CY 2012 will be included in the calculation to determine whether the cap amount has been reached, even though the cap only applies to hospital outpatient therapy services for dates of service from October 1 through December 31. The impact is that the beneficiary will more quickly reach the cap amount.

While modifier -KX can still be used to request an exception to the cap threshold, providers should keep in mind that this modifier attests to CMS that the documentation in the record supports the reasonableness and medical necessity of the extended therapy. Beginning October 1, 2012, all services with the modifier appended will trigger a manual medical review. The exceptions process is set to expire at the end of 2012, so this may be a temporary situation for dates of service from October 1 through December 31 unless Congress steps in.

For more information, see Transmittal R2457CP.

The text of the MCTRJCA can be found at www.gpo.gov/fdsys/pkg/BILLS-112hr3630enr/pdf/BILLS-112hr3630enr.pdf.

**Reporting limits for doses of Provenge**

We received a denial on a claim for Provenge® administration saying that the frequency had been exceeded. Is this some type of medically unlikely edit? We had the appropriate diagnosis and administration codes on the claim.

The edit that stopped payment for the claim is a frequency edit, which means that the service has met the number of times that it can be provided for a Medicare beneficiary.

Effective July 1, CMS has instituted a new edit for Provenge that limits the number of occurrences to three. Based on the manufacturer information, three doses of Provenge are all that are required for treatment. Based on this, CMS instituted an edit that prevents more than three claims (which equates to three doses) for Provenge from being reimbursed. Learn more about the edit in Transmittal 2394.

**Modifier -59 and infusion therapy**

Is it appropriate to use modifier -59 for a patient that is BID (twice daily) on codes 96365 (initial therapeutic infusion, for therapy, prophylaxis, or diagnosis) or 96360 (intravenous infusion, hydration; initial, prophylactic/diagnostic 31 minutes to 1 hour)?

It depends on whether this is one continuous encounter or two separate encounters (e.g., patient presents in the morning, is discharged home, and returns later in the day). If the latter, then modifier -59 would be appropriate to indicate the separateness of the sessions, as long as, of course, the documentation supports this.

Otherwise, report only one initial code for the continuous encounter and all additional hours as “subsequent.”

**Reporting TEE pre- and postoperatively**

If we perform a transesophageal echocardiogram (TEE) pre-procedurally prior to a heart valve replacement, leave the probe in, then perform postoperative images, how would this be billed? Our radiology department would like to bill 93312 (echocardiography, transesophageal, real time with image documentation [2D] [with or without M-mode recording]; including probe placement, image acquisition, interpretation and report) for the TEE, then 93321 (Doppler echocardiography, pulsed wave and/or continuous wave with spectral display [List separately in addition to codes for echocardiographic imaging]; follow-up or limited study) for the postoperative images. I believe we can only code 93312 once based on the guidance of CPT Assistant, January 2000, p. 10. Any help you can provide is appreciated.
A Code 93321 does not bundle to 93312. It is considered an add-on code and may be reported with any of the following codes per the CPT Manual: 93303, 93304, 93308, 93312, 93314, 93315, 93317, 93350, and 93351. The CPT Assistant you mention references codes 93312 and 93314. The image acquisition denoted by code 93314 would indeed be included in code 93312 and cannot be separately reported using any modifier.

**Coding for toxic metabolic encephalopathy**

I need further clarification regarding documentation of toxic metabolic encephalopathy. I have two separate cases in which a physician documents acute mental status change secondary to infectious process. In each case, the patient’s metabolic panels don’t look too bad; however, one of the patients is septic. The physician says that sepsis often denotes encephalopathy, so documenting it separately is “unbundling.” However, I disagree and think that this demonstrates severity. What is the correct logic to use in each of these cases?

Based on the information you’ve provided, code 349.82 (toxic [metabolic] encephalopathy) seems to be a perfect representation of the patient’s documented condition. You indicated that “acute mental status change” was documented due to this infection. According to the National Institute of Neurological Disorders and Stroke, a National Institute of Health, an altered mental state is an inclusive sign of encephalopathy; therefore, it would not be reported separately. Beneath code 780.97 (altered mental status), you will see an Excludes note that directs you to “code to condition” for an altered mental status due to known condition. This notation brings you right back, in this case, to report 349.82.

With regard to the other patient, the physician is required to document all details about the patient’s condition, and in this case, the mention of sepsis in an encephalopathic patient does make a difference in the coding. From the details you’ve provided, code 348.31 (septic encephalopathy) more accurately describes this patient’s condition.

Note that there is a difference between metabolic (septic) encephalopathy and toxic (metabolic) encephalopathy as identified by the cause of the condition. Metabolic (septic) encephalopathy is a diffused brain disease affecting the patient’s brain structure and function that is caused by metabolic dysfunction, a neoplasm in the brain, or other physiological event. Toxic metabolic encephalopathy is a reaction to, or caused by, a toxic substance, which is why code 349.82 requires an additional E code to report the specific toxin.

ICD-9-CM specifically excludes toxic metabolic encephalopathy from code 348.31 and references code 349.82.

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