

QUESTIONS/ANSWERS FROM 2007 CODING WORKSHOP

1. Question: What are the RVU's for the following codes?

43647
43648
43881
43882

Answer: These are carrier priced codes and RVU's are not listed on the CMS Fee Schedule Database. Here is additional information on Carrier priced codes from the WPS website.

http://www.wpsic.com/medicare/provider/carrier_procedures.shtml

2. Question: Is 37210 a bilateral or unilateral code?

Answer: This code is not unilateral or bilateral code as it states embolization of "arteries". You should code it only one time regardless of how many you would do. If the provider would do a large amount maybe over 5 or so they could also add on a 22 modifier.

3. Question: Does one use 17110 & 17111 for common and plantar warts?

Answer: Yes. This is stated in the paranthetical notes following codes 17000 & 17003

4. Clarification of 94620.

A provider/RT needs to include all of these items in the test report section "At rest & with exercise":

Liter Flow of Supplemental O2, O2 Saturation

HR, RR, BP

Level of perceived exertion (Borg Scale)

During Recovery – Must have 5 entries of above data over 5-10 minutes

Also must include:

Patient's Name

Ordering Physician

Date of Test

Diagnosis

Total distance for 6 minute walk (N/A for treadmill)

Comments

Dated Interpretation

Recommendations

Signature

If these requirements are not met provider must bill Simple Test - use O2 saturations with multiple determinations - code 94761 per the AMA

5. Question: What if 94774 is performed multiple times? (In other words, what if 2 interps are performed in less than 30 days due to the machine being full, requiring multiple interps)? Is this code billed x2 or only reported once?

Answer: Due to the fact that these codes are broken out in to particular portions of the actual entire global, if you were doing a second download of the machine it would probably be more appropriate to bill 94776 - monitoring, download of information, receipt of transmission(s) and

analyses by computer only. If the physician is doing a second reading of a patient's monitor within a 30 day period it might be appropriate to bill 94777 for physician review, interpretation and preparation of report only. Just be sure that the data does not overlap and he is not billing for something he previously read. The physician again would have to have a separate interpretation and report for these service of 94777.

6. Question: Category II codes – Do they have anything to do with pay for performance?

Answer: The whole purpose the AMA created the Category II codes is for performance measurement.

See this link:

<http://www.ama-assn.org/ama/pub/category/10616.html>

<http://health-information.advanceweb.com/common/editorial/editorial.aspx?CC=42599>

I would also encourage you to refer to the link below for the Physician Voluntary Reporting Program (PVRP).

http://www.cms.hhs.gov/PVRP/01_Overview.asp

7. Question: Are there Digital mammography codes and what are they?

Answer: Please see HCPCS codes G0202-G0206. G0202 Screening mammography bilateral all views, G0204 Diagnostic mammography bilateral all views, G0206 Diagnostic mammography unilateral all views

8. Question: My question is...In the 2007 EXPERT edition of the ICD-9-CM volume 1 & 2 several of the codes we use for our lab tests have been changed to secondary diagnoses. Examples are the V58.61, V58.69, V45.81. How can we correctly code our labs like an INR for high risk medication use after a CABG when both the med use and the CABG are secondary diagnoses? So far we have not received information from any insurances that they are changing the way they will reimburse for these diagnoses.

Answer: Question submitted to the American Hospital Association (AHA) for clarification. Answer will be posted when received.

9. Question: Due to the fact that the 17000 now has actinic keratoses in, is there an expectation to use that code, rather than the excision of benign lesions? Most of the time you are waiting for a path report before you would report the actinic keratoses.

Answer: Yes, the verbiage was changed this year to delineate between the destruction of the benign and pre-malignant lesions. The problem is that there is controversy in the academic medical field as to where to actinic keratoses fall in to. Some providers feel that they are early cancers other feel that they are pre-malignant. You will want to confer with your provider as to which codes they feel you should report.

10. Question: What is the website to be able to locate the impacted x-rays for the contiguous sites for Medicare's reduction of 25% of fees?

Answer:

<http://www.gehealthcare.com/usen/community/reimbursement/docs/FAQMultImagProcDisc.pdf>

11. Question: Where can I find information about the AAA screening G0329 paid by Medicare?

Answer: MM5235 - Implementation of a One-Time Only Ultrasound Screening for Abdominal Aortic Aneurysms (AAA), Resulting from a Referral from an Initial Preventive Physical Examination

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5235.pdf>

12. Question: What is the difference in RVU's for Vent Management vs. Critical Care?

Answer: The following RVU's are based on total transitional non-facility RVU's for 2007

Critical Care 99291 is 7.21

Vent Mgmt Initial 94002 is 2.42

However, Subsequent Care is different

Inpatient subsequent is

99231 - 1.02

99232 - 1.82

99233 - 2.60

Subsequent day vent management is

94003 - 1.76

Therefore, if you were coding for reimbursement and it was a critical care situation, it is obviously better to bill the critical care. If you are choosing between E&M or vent management (because it's either or) the vent management would be the way to go.

13. Question: Is a "cc" acceptable as the reply component to the consultation, back to requesting physician in regards to a consultation? A conference attendee had been told by a national consultant that the "cc" was unacceptable.

Answer: According to the WPS FAQ's this answer was found:

In regards to consults, is a copy of the consulting physician's note sent to the requesting physician, sufficient documentation for the guideline in PHYS-006 on consult criteria that states "a written report from consulting physician to the referring physician?" **After a consultation has been completed, provision of a copy of the consulting physician's note to the referring physician can satisfy the Medicare requirement of a written report from the consulting physician to the referring physician. The consulting physician's note, however, must contain the referring physician's name, plus evidence that the referring physician requested both the consultation and the consulting physician's opinion.** *A telephone communication, alone, from the consulting physician will not satisfy the requirement. There must be a written report from the consultant. (In addition, all the additional criteria for a consultation that have been set forth in IOM 100-4 Chapter 12 A must have been met.)*

Rev. (04/10/06)

14. Question: Can an office bill both a 99211 and 90772 and the HCPCS code for a Depo-Provera Injection?

Answer: For Commercial insurance companies: You should bill the J code and **either** the 90772 **OR** 99211, only. This depends completely whether or not the physician is supervising the procedure (he is in the office – 90772) or whether the nurse is performing the injection

"independently but under his supervision – he is not in the office" – 99211. You cannot bill both at the same time even if you do a set of vitals, etc. (These should be taken regardless).

For Medicare patients you would follow these regulations:

*The CPT 2006 includes a parenthetical remark immediately following CPT code 90772 (Therapeutic, prophylactic or diagnostic injection; (specify substance or drug); subcutaneous or intramuscular.) It states, "Do not report 90772 for injections given without direct supervision. To report, use 99211."

*This coding guideline does not apply to Medicare patients. If the RN, LPN or other auxiliary personnel furnishes the injection in the office and the physician is not present in the office to meet the supervision requirement, which is one of the requirements for coverage of an incident to service, then the injection is not covered. The physician would also not report 99211 as this would not be covered as an incident to service.

Links to websites:

HCPCS file for 2007

<http://www.cms.hhs.gov/HCPCSReleaseCodeSets/ANHCPCS/list.asp>

CMS RVU file

<http://www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1188616&intNumPerPage=10>

Information for Billing 99211 in WPS jurisdiction:

June 2006 Communique

<http://www.wpsmedicare.com/provider/pdfs/0606comm.pdf>

Cert Error Focus Rate on 99211

http://www.wpsmedicare.com/provider/cert_error_focus.shtml