



## December 2011 Edition

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The holiday season is here and the December edition of *Chargemaster Corner* would like to spread a little holiday cheer by reviewing a few 2012 coding updates for the chargemaster. While not all coding revisions can be reviewed in a single newsletter edition, this final newsletter for 2011 will focus on those codes which have the greatest reimbursement impact under the OPSS payment system.

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The following articles are found in this month's edition:

- Overview from OptumInsight's 11<sup>th</sup> ECBC Conference, Las Vegas
- Infusions and Injections for 2012
- Rehabilitation Services for 2012
- New NCCI Manual Posted on CMS Website
- Correction

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### Essential Coding and Billing Conference #11

The ECBC was held at Planet Hollywood November 28<sup>th</sup> – 30<sup>th</sup> in Las Vegas and was a huge success. For those of you who attended this annual event, you were fortunate to attend sessions conducted by industry-recognized experts who reviewed the OIG's Work Plan for 2012, provided in-depth discussions of the 2012 OPSS Final Rule, study the CPT and HCPCS coding changes for both hospitals and physicians, as well as analyze the ICD-10-CM/PCS coding changes, as well as numerous other useful sessions. This year was one of the most-attended conferences and is scheduled at the best time of each year, allowing hospitals and providers time to prepare for implementation of the new information received. If you have never attended this conference in the past, mark your calendars and plan to attend in 2012. The conference will be held at the Bellagio, one of the most prestigious casino properties in Las Vegas. Continue checking the website for scheduled dates at <http://www.shopingix.com>.

We also welcome many new subscribers to the *Chargemaster Corner* family. Having attended the 2012 Chargemaster CPT/HCPCS Update Sessions, those attendees who provided e-mail addresses have been added to the distribution list. We welcome you and hope you find this edition as well as future newsletters helpful.

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### Injections and Infusions

Only one CPT code for 2012 underwent a change. A descriptor revision, a simple clarification, is a simple change yet thought to have previously been understood by providers. The new 2012 code descriptor reads:

*CPT 96367 Intravenous infusion, for therapy, prophylaxis, or diagnosis (specify substance or drug); additional sequential infusion of a new drug/substance, up to 1 hour (List separately in addition to code for primary procedure) (Status Indicator S).*

Clarifying instructions and reporting scenarios are noted in the 2012 CPT code book for initial, sequential as well as concurrent infusion. These paragraphs are noted in green font and should be reviewed as well as the parenthetical coding statements noted throughout this clinical section. Providers are again reminded that when multiple infusions of the same drug/substance are administered on the same date of service, the initial code should be selected. Second and subsequent infusion(s) should be reported based on the individual time(s) of each additional infusion(s) of the same drug/substance using the appropriate ad-on code. Providers are also instructed that when infusions last beyond midnight, the date in which the infusion was started would be the date used to report total units of time provided. A "keep open" infusion of any type is not separately reported. This keep open rate can certainly vary by facility and even by patient, and physicians should assist in establishing the standard definition of "keep open" along with flow rate for the facility. This clarification will certainly provide a consistent guideline for all professionals to use as reference. CMS has never changed their stance from their original reporting instructions for infusions and injections. This year's code books contain the same statement as the 2011 reporting instructions, advising providers that when two pushes are administered, one before and the second after midnight, two initial administration codes should be reported. After the 2011 code books were distributed, CMS clarified drug administration services, issuing Transmittal R2130CP, referencing Pub. 100-04, Medicare Claims Processing Manual, Chapter 4, Section 230.2. CMS has never changed reporting guidelines and continues state "hospitals should report only one initial drug administration service, including infusion services, per encounter for each distinct vascular access site. Medicare stated "Although new CPT guidance has been issued for reporting initial drug administration services, Medicare contractors are to continue to follow the guidance given in this manual."

Once again, providers should ignore this printed reporting instruction found published in the 2012 CPT book, and follow Medicare's reporting guidelines in the Medicare Claims Processing Manual.

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## Rehabilitation Services for 2012

### Lymphedema Therapies

Occupational as well as physical therapists treat patients suffering from lymphedema. One of the challenges in the treatment and management of lymphedema are the limited number of CPT codes specific for management of this medical condition.

CPT code 29581 *Application of multi-layer venous wound compression system, below knee* has been revised for 2012 and will no longer contain the reference to “wound” compression system. Rather, this code will be consistent for reporting “multilayer” compression system applications with the following “new” codes next year:

CPT 29581 *Application of multi-layer venous wound compression system, leg (below knee), including ankle and foot*

CPT 29582 *Application of multi-layer venous wound compression system; thigh and leg, including ankle and foot, when performed*

CPT 29583 *Application of multi-layer venous wound compression system; upper arm and forearm*

CPT 29584 *Application of multi-layer venous wound compression system; upper arm, forearm, hand, and fingers*

Additional parenthetical statements contained beneath the above CPT codes include those procedures not separately reportable in combination with these codes. An interesting inclusion to the non-reportable CPT codes with the above procedures is CPT 97140 *Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes*, the procedure used by most therapists to report the treatment for lymphatic drainage in the department. Based on these instructions, therapists may treat and provide lymphatic drainage but may not report both CPT 97140 and the 2958X codes on the same date of service. Providers are encouraged to review the above CPT codes as well as the new reporting comments in the 2012 CPT book.

### Speech Therapy

Most speech therapy treatments and evaluations do not include a time element. For 2012, CPT 92605, *Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour* will include a time element, the initial or first hour. For reporting each additional 30 minutes, a new CPT code was created for 2012 and is as follows:

CPT 92618, *Evaluation for prescription of non-speech-generating augmentative and alternative communication*

*device, face-to-face with the patient; each additional 30 minutes (List separately in addition to code for primary procedure)*

Listed out of sequence in the 2012 CPT book, instructions guide the provider to report CPT 92618 as an add-on code with revised CPT code 92605.

### Audiology

The appropriate revenue code for reporting audiology services is 0470 (Audiology; General Classification). Several new codes are added for audiologists to utilize for reporting services and treatments next year.

New for 2012 is **CPT 92558** *Evoked otoacoustic emissions, screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis*. An automated analysis, this code will be used to report evoked otoacoustic emissions screenings. Should the newborn baby not pass the initial hearing screening exam usually performed shortly after birth, the healthcare professional performs an otoscopic examination of each ear. An automated otoacoustic emission screening protocol will stimulate the test and the test results recorded. Medicare does not cover this screening exam as evidenced by the status indicator of “E”.

Two existing CPT codes underwent descriptor revisions for 2012, now reportable based on the limited number of frequencies tested to determine if the patient has experienced hearing loss.

CPT 92587, *Distortion product evoked otoacoustic emissions; limited evaluation to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report*

CPT 92588, *Distortion product evoked otoacoustic emissions; comprehensive or diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report*

For central auditory function evaluation, see 92960, 92621. Added verbiage to CPT 92621 now mandates this code as an add-on code, reportable with CPT 92620.

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### Radiology and Associated Departments

In 2012, radiology professionals will be faced with significant changes to diagnostic and interventional radiology procedure codes and coding guidelines. The theme from previous years for collapsing the radiology supervision and interpretation procedures into the surgical CPT code has carried over into 2012 once again. The

changes will affect lung and hepatobiliary scans for nuclear medicine departments, spine x-rays, renal artery catheterization and imaging, vena cava filter procedures, paracentesis, vertebroplasty, as well as sacroiliac joint injections. With the collapse of more supervision and interpretation procedures, the radiology department may have fewer charge lines to report their services, yet staffing requirements and costs remain a constant.

A new CPT code was created for CTA (Computed Tomographic Angiography) of the abdomen and pelvis. Similar to the combined CPT codes for CT pelvis and abdomen, the CTA abdomen and pelvis procedures are reported using a single code.

The following is a new “combo” CPT code for 2012

CPT 74174 *Computed tomographic angiography, abdomen and pelvis, with contrast material(s), including noncontrast images, if performed, and image postprocessing* (Status indicator “S”)

The stand-alone CTA abdomen code (74175) and CTA pelvis code (72191) will remain, as there are times a CTA abdomen or a CTA pelvis will be performed as a single procedure. The combined CTA abdomen and pelvis study code should not be reported in conjunction with the other CTA abdomen, pelvis, lower extremity, aorto-iliofemoral runoff or 3-D codes (72191, 73706, 74175, 75635, 76376, 76377).

The CTA aorto-iliofemoral runoff code, 75635, includes CTA of the abdomen and pelvis; therefore, it is not appropriate to report CPT 75635 in conjunction with the combined CTA abdomen and pelvis code.

Code 77079, *Computed tomography bone mineral density study of the appendicular skeleton (e.g., radius, wrist, heel)* and CPT code 77083, *Radiographic absorptiometry (e.g., photodensitometry, radiogrammetry, 1 or more sites)* are deleted in 2012. These procedures are obsolete and have been replaced by newer technology. Codes 77080 (axial), 77081 (appendicular) and 77082 (vertebral fracture assessment) remain and are available to describe dual-energy X-ray absorptiometry bone density studies of one or more sites.

The radiological component (S&I) for reporting percutaneous placement of the IVC filter will be a casualty for radiology departments having been deleted in 2012. CPT 75940 will be replaced by three new surgical CPT codes that include both the procedure as well as the imaging. These procedures are differentiated by insertion, repositioning and retrieval (removal) of the intravascular vena cava filter. The new combined and complete surgical CPT codes are noted as follows:

CPT 37191 *Insertion of intravascular vena cava filter, endovascular approach inclusive of vascular access, vessel selection, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy)* (Status Indicator T)

CPT 37192 *Repositioning of intravascular vena cava filter, endovascular approach inclusive of vascular access, vessel selection, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy)* (Status Indicator T)

CPT 37193 *Retrieval (removal) of intravascular vena cava filter, endovascular approach inclusive of vascular access, vessel selection, and all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance (ultrasound and fluoroscopy)* (Status Indicator T)

Also created for 2012 is CPT 37619, *Ligation of inferior vena cava*, and is described as the interruption, partial or complete, of inferior vena cava by suture, ligation, plication, clip, extravascular, intravascular (umbrella device). This open surgical procedure is usually done via a laparotomy or retroperitoneal exposure.

Radiological guidance is typically used when performing an abdominal paracentesis. Whether ultrasound, CT or fluoroscopic guidance is used, the new 2012 surgical CPT codes will include image guidance and will not be separately reportable. These new codes are noted as follows:

CPT 49082 *Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance* (Status indicator T)

CPT 49083 *Abdominal paracentesis (diagnostic or therapeutic); with imaging guidance* (Status indicator T)

CPT 49084 *Peritoneal lavage, including imaging guidance, when performed* (Status indicator T)

Since CPT 49082 does not utilize radiological guidance, the chargemaster may certainly not contain this specific procedure.

CPT 49080 *Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); initial* and CPT 49081 *Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic); subsequent* have been deleted for 2012. Replacement codes are one of the three new codes discussed above.

The radiological supervision and interpretation CPT code 73542 *Radiological examination, sacroiliac joint arthrography, radiological supervision and interpretation* will also be deleted in 2012. To accommodate the image guidance for this arthrogram, the description for CPT 27096 will be revised to read as follows:

*CPT 27096 Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed (Status indicator B)*

The sacro-iliac (SI) joint injection CPT code 27096 is being used inappropriately by some providers to describe a minimal contrast injection confirmation of needle position in the joint when doing a therapeutic injection. Code 27096 should only be reported when imaging guidance is used. Therefore, CPT code 27096 was revised to bundle sacroiliac (SI) joint therapeutic injections with imaging in order to stop this inappropriate reporting. Because CPT 27096 is to be used for imaging confirmation of intra-articular needle positioning, a cross-reference under CPT code 27096 directs the coder to use CPT code 20552, Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s) when imaging is not performed.

CPT 27096 remains status indicator of B in 2012, and for Medicare reporting, the following HCPCS codes should continue:

G0259 *Injection procedure for sacroiliac joint; arthrography*

G0260 *Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography*

Diagnostic renal arteriography will be placed in a separate family of codes for 2012. Unilateral as well as bilateral renal angiography codes will be replaced by fur new surgical CPT codes which contain image guidance. CPT codes 75722, 75724 will be deleted. The new codes are noted below:

*CPT 36251 Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiologic supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral (Status Indicator Q2)*

*CPT 36252 Selective catheter placement (first-order), main renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture and catheter placement(s), fluoroscopy, contrast injection(s), image*

*postprocessing, permanent recording of images, and radiologic supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed bilateral (Status Indicator Q2)*

*CPT 36253 Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiologic supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; unilateral (Status Indicator Q2)*

*CPT 36254 Superselective catheter placement (one or more second order or higher renal artery branches) renal artery and any accessory renal artery(s) for renal angiography, including arterial puncture, catheterization, fluoroscopy, contrast injection(s), image postprocessing, permanent recording of images, and radiologic supervision and interpretation, including pressure gradient measurements when performed, and flush aortogram when performed; bilateral (Status Indicator Q2)*

Providers are drawn to CPT codes 36253 and 36254 where “superselective” catheter placements are included in the code descriptors, indicating the catheter was placed in a second order or higher vessel. The above new surgical CPT codes are all inclusive, containing the image guidance, which is no longer separately reportable in 2012 for these procedures.

The panoramic projection has been revised for 2012 to read: CPT 70355 Orthopantomogram (eg, panoramic x-ray) (Status indicator “X”) An editorial revision was made to CPT 70355 to list a panoramic x-ray as an example of this type of study.

It is believed that code 76101, *Radiologic examination, complex motion (ie, hypercycloidal) body section (eg, mastoid polytomography), other than with urography; unilateral* is being used inappropriately by dentists and oral surgeons to describe a Panorex study. Therefore, a cross-reference also was added following code 76101 directing the coder to use 70355 to describe a panoramic x-ray study.

### Lumbosacral Spine

Two CPT codes reflect new descriptors for 2012:

*CPT 72114 Radiologic examination, spine, lumbosacral; complete, including bending views, **minimum of 6 views** (Status indicator “X”)*

*CPT 72120 Radiologic examination, spine, lumbosacral; bending views only, **2 or 3 views** (Status indicator “X”)*

Currently, there appears to be confusion as to what constitutes a complete (72114) versus minimum 4-view (72110) versus bending views only (72120) study of the lumbosacral spine. To provide clarification, descriptor changes were made to CPT codes 72114 and 72120 to clearly differentiate when these codes should be reported. Bending views are included in a minimum six-view study of the lumbosacral area (CPT 72114) and are therefore not reported separately. Bending views only are reported with CPT code 72120. Bending views performed in conjunction with any other type of views are reported with the appropriate code, i.e., CPT 72100 (2 or 3 views) or CPT 72110 (minimum of 4 views)

Another revision was specific for image-guidance fluoroscopy CPT code 71090, *Insertion pacemaker, fluoroscopy and radiography, radiological supervision and interpretation*. Image guidance is now included in codes 33206-33249. In the Radiology section, a cross-reference has been added, instructing providers to report CPT 33206-33249 for pacemaker or pacing cardioverter-defibrillator lead insertions, replacement or revision procedures with fluoroscopic guidance. Interestingly is the recommendation to report CPT 76000 *Fluoroscopy (separate procedure), up to 1 hour physician time, other than 71023 or 71034 (e.g., cardiac fluoroscopy)*, when fluoroscopic guidance is used for diagnostic lead evaluation without lead insertion, replacement or revision. CPT 71090 has been deleted, which is expected to impact not only radiology, but also cardiac cath and cardiology departments' chargemasters.

Other revisions are noted for nuclear medicine and radiation oncology. Although felt to have minimal revisions, the facility may certainly find the need to add the new codes for next year. Please refer to that section of new codes for review.

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### New NCCI Edit Manual

Although the NCCI was initially developed for use by Medicare Carriers (A/B MACs processing practitioner service claims) to process Part B claims, many of the edits were added to the Outpatient Code Editor (OCE) in August, 2000, for use by Fiscal Intermediaries (A/B MACs processing outpatient hospital service claims). Some of the edits applied to outpatient hospital claims through the OCE. Up to now, the hospital's edits were one quarter behind those for the Part B providers.

However, effective January 1, 2012, NCCI edits in OCE appear synchronously with NCCI edits for practitioners. All providers (technical and professional) will have claims processed using a complete and standardized set of NCCI edits.

In the revised manual, many policies are described utilizing the term "physician". Unless indicated differently, the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes.

Thirteen chapters comprise the NCCI Manual, each for a specific clinical section of the CPT book. A side-by-side comparison of coding guidelines should be performed to identify specific coding revisions. One quick change is noted below:

Chapter 12 includes the following new instructions:

*12. HCPCS code G0434 (drug screen..., by CLIA waived test or moderate complexity test, per patient encounter) is utilized to report urine drug screening performed by a test that is CLIA waived or CLIA moderate complex. The code is reported with only one (1) unit of service regardless of the number of drugs screened. HCPCS code G0431 (drug screen... by high complexity test method..., per patient encounter) is utilized to report drug urine screening performed by a CLIA high complexity test method. This code is also reported with only one (1) unit of service regardless of the number of drugs screened. If a provider performs urine drug screening, it is generally not necessary for that provider to send an additional specimen from the patient to another laboratory for urine drug screening for the same drugs.* Website: <https://www.cms.gov/NationalCorrectCodInitEd/>

There is an MUE in place but the facility can append a modifier for each subsequent drug screen and bill greater than one unit. Based on these new instructions, the MUE should be bypassed ONLY when the patient presents for two separate encounters and the facility performs a second/subsequent drug screen during the second patient encounter. Modifier -59 or -91 would be appropriate to report with the second HCPCS G0431 .

Stay tuned, more discussions on NCCI changes will be coming in next month's *Chargemaster Corner*.

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### Correction

A reader pointed out that an incorrect reference was provided in the November's *Chargemaster Corner* article **RAC Posted Issues Becoming Personal Reality**. The stated reference was *Claims Processing Manual, Chapter 25, Section 10.2.2*. It should have stated *Claims Processing Manual, Chapter 18 (Preventative Screening and Services), Section 10.2.2*.

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We hope you enjoy receiving the *Chargemaster Corner* from OptumInsight. Each month OptumInsight will circulate this newsletter via e-mail to those interested parties who have provided contact information either via e-mail request or who have completed an informational form when attending a number of educational seminars conducted nationwide. Please share this e-mail with your co-workers and encourage them to contact OptumInsight via [Chargemaster.corner@gmail.com](mailto:Chargemaster.corner@gmail.com). Contact information will not be shared with any other organization and used *only* for means of distributing this monthly newsletter. For direct contact concerning receipt of this newsletter, please e-mail your comments to the above noted e-mail address. Thank you for your interest in this monthly chargemaster newsletter and hope you find it helpful.

Under “Coding Central” you will find an archive for previous *Chargemaster Corner* articles as well.



Happy Holidays from all of our *Chargemaster Corner* staff to you and your family. See you in 2012!!!

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Please take time to review the resources found on this site, and bookmark the page as updates and new coding scenarios are posted. You may find the site at:  
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