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FROM THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) 2010 Changes to the Hospital Outpatient Prospective Payment System (HOPPS)

Payment for Multiple Imaging Composite APCs

Effective for services furnished on or after January 1, 2009, multiple imaging procedures performed during a single session using the same imaging modality are paid by applying a composite APC payment methodology. The services are paid with one composite APC payment each time a hospital bills for second and subsequent imaging procedures described by the HCPCS codes in one imaging family on a single date of service. The Outpatient Code Editor (OCE) logic determines the assignment of the composite APCs for payment.

The composite APC payment methodology for multiple imaging services utilizes three imaging families (Ultrasound, CT and CTA, and MRI and MRA) and five composite APCs: APC 8004 (Ultrasound Composite), APC 8005 (CT and CTA without Contrast Composite), APC 8006 (CT and CTA with Contrast Composite), APC 8007 (MRI and MRA without Contrast Composite), and APC 8008 (MRI and MRA with Contrast Composite). When a procedure is performed with contrast during the same session as a procedure without contrast, and the two procedures are within the same family, the "with contrast" composite APC (either APC 8006 or 8008) is assigned.

CMS has updated the list of specified HCPCS codes within the three imaging families and five composite APCs to reflect HCPCS coding changes for CY 2010. Specifically, they added CPT code 74261 (*Computed tomographic (CT) colonography, diagnostic, including image postprocessing; without contrast material*) and

CPT code 74262 (*Computed tomographic (CT) colonography, diagnostic, including image post-processing, with contrast material(s) including non-contrast images, if performed*) to the CT and CTA family, and removed CPT code 0067T (*Computed tomographic (CT) colonography (ie, virtual colonoscopy; diagnostic)*), which was replaced by these CPT codes.

Reporting HCPCS Codes for All Drugs, Biologicals, and Radiopharmaceuticals

Hospitals are strongly encouraged to report charges for all drugs, biologicals, and radiopharmaceuticals, regardless of whether the items are paid separately or packaged, using the correct HCPCS codes for the items used. It is also of great importance that hospitals billing for these products make certain that the reported units of service of the reported HCPCS codes are consistent with the quantity of a drug, biological, or radiopharmaceutical that was used in the care of the patient.

More complete data from hospitals on the drugs and biologicals provided during an encounter would help improve payment accuracy for separately payable drugs and biologicals in the future. CMS strongly encourages hospitals to report HCPCS codes for all drugs and biologicals furnished, if specific codes are available.

CMS' longstanding policy under the OPPS is to refrain from instructing hospitals on the appropriate revenue code to use to charge for specific services. While CMS does not require hospitals to use revenue code 0636 (Pharmacy-Extension of 025x; Drugs Requiring De-

tailed coding) when billing for drugs and biologicals that have HCPCS codes, whether they are separately payable or packaged, CMS believes that a practice of billing all drugs and biologicals with HCPCS codes under revenue code 0636 would be consistent with National Uniform Billing Committee (NUBC) billing guidelines and would provide it with the most complete and detailed information for future ratesetting. CMS' standard ratesetting methodology is to rely on hospital cost and charge information as it is reported to us by hospitals through the claims data and cost reports.

CMS reminds hospitals that under the OPPS, if two or more drugs or biologicals are mixed together to facilitate administration, the correct HCPCS codes should be reported separately for each product used in the care of the patient. The mixing together of two or more products does not constitute a "new" drug as regulated by the Food and Drug Administration

(FDA) under the New Drug Application (NDA) process. In these situations, hospitals are reminded that it is not appropriate to bill HCPCS code C9399. HCPCS code C9399, Unclassified Drug or Biological, is for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, for which a HCPCS code has not been assigned.

Unless otherwise specified in the long description, HCPCS descriptions refer to the non-compounded, FDA-approved final product. If a product is compounded and a specific HCPCS code does not exist for the compounded product, the hospital should report an appropriate unlisted code such as J9999 or J3490.

Changes to CY 2010 HCPCS Codes for Certain Drugs, Biologicals, and Radiopharmaceuticals

The following drug HCPCS codes have description revisions in 2010:

CY 2009 HCPCS Code	CY 2009 Long Descriptor	CY 2010 HCPCS Code	CY 2010 Long Descriptor
90378	Respiratory syncytial virus immune globulin (RSV-IgIM), for intramuscular use, 50 mg, each	90378	Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each
90663	Influenza virus vaccine, pandemic formulation	90663	Influenza virus vaccine, pandemic formulation, H1N1
90669	Pneumococcal conjugate vaccine, polyvalent, when administered to children younger than 5 years, for intramuscular use	90669	Pneumococcal conjugate vaccine, 7 valent, for intramuscular use
A9500	Technetium tc-99m sestamibi, diagnostic, per study dose, up to 40 millicuries	A9500	Technetium tc-99m sestamibi, diagnostic, per study dose
A9535	Injection, methylene blue, 1 ml	Q9968	Injection, non-radioactive, non-contrast, visualization adjunct (e.g., methylene blue, isosulfan blue), 1 mg
A9605	Samarium sm-153 lexicronamm, therapeutic, per 50 millicuries	A9604	Samarium SM-153 lexicronam, therapeutic, per treatment dose, up to 150 millicuries
C9245	Injection, romiplostim, 10 mcg	J2796	Injection, Romiplostim, 10 micrograms
C9246	Injection, gadoxetate disodium, per ml	A9581	Injection, gadoxetate disodium, 1 ml
C9247	Iobenguane, I-123, diagnostic, per study dose, up to 10 millicuries	A9582	Iodine I-123 iobenguane, diagnostic, per study dose, up to 15 millicuries
C9249	Injection, certolizumab pegol, 1 mg	J0718	Injection, certolizumab pegol, 1 mg
C9251	Injection, C1 esterase inhibitor (human), 10 units	J0598	Injection, C1 esterase inhibitor (human), 10 units

CY 2009 HCPCS Code	CY 2009 Long Descriptor	CY 2010 HCPCS Code	CY 2010 Long Descriptor
C9252	Injection, plerixafor, 1 mg	J2562	Injection, Plerixafor, 1 mg
C9253	Injection, temozolomide, 1 mg	J9328	Injection, temozolomide, 1 mg
C9358	Dermal substitute, native, nondenatured collagen (SurgiMend Collagen Matrix), per 0.5 square cm	C9358	Dermal substitute, native, non-denatured collagen, fetal bovine origin (SurgiMend Collagen Matrix), per 0.5 square centimeters
C9359	Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Putty, Integra OS Osteoconductive Scaffold Putty), per 0.5 cc	C9359	Porous purified collagen matrix bone void filler (Integra Mozaik Osteoconductive Scaffold Putty, Integra OS Osteoconductive Scaffold Putty), per 0.5 cc
J0460	Injection, atropine sulfate, up to 0.3 mg	J0461	Injection, atropine sulfate, 0.01 mg
J0530	Injection, penicillin g benzathine and penicillin g procaine, up to 600,000 units	J0559	Injection, penicillin G benzathine and penicillin G procaine, 2500 units
J0540	Injection, penicillin g benzathine and penicillin g procaine, up to 1,200,000 units	J0559	Injection, penicillin G benzathine and penicillin G procaine, 2500 units
J0550	Injection, penicillin g benzathine and penicillin g procaine, up to 2,400,000 units	J0559	Injection, penicillin G benzathine and penicillin G procaine, 2500 units
J0585	Botulinum toxin type a, per unit.	J0585	Injection, onabotulinumtoxina, 1 unit
J0587	Botulinum toxin type b, per 100 units	J0587	Injection, rimabotulinumtoxinb, 100 units
J0835	Injection, cosyntropin, per 0.25 mg	J0833	Injection, cosyntropin, not otherwise specified, 0.25 mg
J0835	Injection, cosyntropin, per 0.25 mg	J0834	Injection, cosyntropin (cortrosyn), 0.25 mg
J1565	Injection, respiratory syncytial virus immune globulin, intravenous, 50 mg	90379	Respiratory syncytial virus immune globulin (rsv-igiv), human, for intravenous use
J7192	Factor viii (antihemophilic factor, recombinant) per i.u.	J7192	Factor viii (antihemophilic factor, recombinant) per i.u., not otherwise specified
J7322	Hyaluronan or derivative, synvisc, for intra-articular injection, per dose	J7325	Hyaluronan or derivative, synvisc or synvisc-one, for intra-articular injection, 1 mg
J9170	Injection, docetaxel, 20 mg	J9171	Injection, docetaxel, 1 mg
Q2009	Injection, fosphenytoin, 50 mg	Q2009	Injection, Fosphenytoin, 50 mg phenytoin equivalent
Q2023	Injection, factor viii (antihemophilic factor, recombinant) (Xyntha), per i.u.	J7185	Injection, factor viii (antihemophilic factor, recombinant) (xyntha), per i.u.
Q2024	Injection, bevacizumab, 0.25 mg	C9257	Injection, bevacizumab, 0.25 mg

Drugs and Biologicals with Payments Based on Average Sales Price (ASP) Effective January 1, 2010

For CY 2010, payment for non pass-through drugs, biologicals, and therapeutic radiopharmaceuticals is made at a single rate of average sales price (ASP)+4 percent, which provides payment for both the acquisition cost and pharmacy overhead costs associated with the drug, biological, or therapeutic radiopharmaceutical. In CY 2010, a single payment of ASP+6 percent for pass-through drugs, biologicals, and radiopharmaceuticals is made to provide payment for both the acquisition cost and pharmacy overhead costs of these pass-through items.

In the CY 2010 OPPTS/ASC final rule with comment period, CMS states that payments for drugs and biologicals based on ASPs will be updated on a quarterly basis as subsequent quarter ASP submissions become available. Effective January 1, 2010, payment rates for many drugs and biologicals have changed from the values published in the CY 2010 OPPTS/ASC final rule with comment period as a result of the new ASP calculations based on sales price submissions from the third quarter of CY 2009. In cases where adjustments to payment rates are necessary, changes to the payment rates will be incorporated in the January 2010 release of the OPPTS Pricer. The updated payment rates effective January 1, 2010 can be found in the January 2010 update of the OPPTS Addendum A and Addendum B at <http://www.cms.hhs.gov/HospitalOutpatientPPS/AU/list.asp> on the CMS Web site.

Correct Reporting of Biologicals When Used As Implantable Devices

When billing for biologicals where the HCPCS code describes a product that is solely surgically implanted or inserted, whether the HCPCS code is identified as having pass-through status or not, hospitals are to report the appropriate HCPCS code for the product. In circumstances where the implanted biological has pass-through status, either as a biological or a device, a separate payment for the biological or device is made. In circumstances where the implanted biological does not have pass-through status, the OPPTS payment for the biological is packaged into the payment for the associated procedure.

When billing for biologicals where the HCPCS code describes a product that may either be surgically implanted or inserted or otherwise applied in the care

of a patient, hospitals should not separately report the biological HCPCS codes, with the exception of biologicals with pass-through status, when using these items as implantable devices (including as a scaffold or an alternative to human or nonhuman connective tissue or mesh used in a graft) during surgical procedures. Under the OPPTS, hospitals are provided a packaged APC payment for surgical procedures that includes the cost of supportive items, including implantable devices without pass-through status. When using biologicals during surgical procedures as implantable devices, hospitals may include the charges for these items in their charge for the procedure; report the charge on an uncoded revenue center line, or report the charge under a device HCPCS code (if one exists) so these costs would appropriately contribute to the future median setting for the associated surgical procedure.

Reporting of Outpatient Diagnostic Nuclear Medicine Procedures

CMS applies nuclear medicine procedure-to-radiolabeled product edits in the OCE effective January 2008 that require a radiolabeled product to be present on the same claim as a nuclear medicine procedure for payment under OPPTS to be made. These edits have been revised quarterly, based on information provided by members of the public with regard to certain clinical scenarios. CMS is updating the lists of nuclear medicine procedures and radiolabeled products for CY 2010. The complete list of updated nuclear medicine procedure-to-radiolabeled product edits can be found at http://www.cms.hhs.gov/HospitalOutpatientPPS/02_device_procedure.asp#TopOfPage on the CMS website.

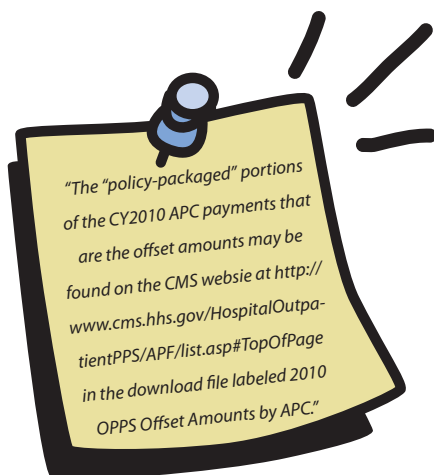
With the specific exception of HCPCS code C9898 (Radiolabeled product provided during a hospital inpatient stay) to be reported by hospitals on outpatient claims for nuclear medicine procedures to indicate that a radiolabeled product that provides the radioactivity necessary for the reported diagnostic nuclear medicine procedure was provided during a hospital inpatient stay, hospitals should only report HCPCS codes for products they provide in the hospital outpatient department and should not report a HCPCS code and charge for a radiolabeled product on the nuclear medicine procedure-to-radiolabeled product edit list solely for the purpose of bypassing those edits present in the I/OCE.

As stated in the October 2009 OPPS update, in the rare instance when a diagnostic radiopharmaceutical may be administered to a beneficiary in a given calendar year prior to a hospital furnishing an associated nuclear medicine procedure in the subsequent calendar year, hospitals are instructed to report the date the radiolabeled product is furnished to the beneficiary as the same date that the nuclear medicine procedure is performed. CMS believes that this situation is extremely rare, and we expect that the majority of hospitals will not encounter this situation.

Effective January 1, 2010 there will be 1 diagnostic radiopharmaceutical receiving pass-through payment. For APCs containing nuclear medicine procedures, the Pricer will reduce the amount of the pass-through diagnostic radiopharmaceutical payment by the wage-adjusted offset for the APC with the highest offset amount when the radiopharmaceutical with pass-through appears on a claim with a nuclear procedure. The offset will cease to apply when the diagnostic radiopharmaceutical expires from pass-through status. The offset amounts for diagnostic radiopharmaceuticals are the “policy-packaged” portions of the CY 2010 APC payments for nuclear medicine procedures and may be found at <http://www.cms.hhs.gov/HospitalOutpatientPPS/APF/list.asp#TopOfPage> in the download file labeled 2010 OPPS Offset Amounts by APC.

Introduction of Payment Offset for Pass-Through Contrast Agents

Effective for pass-through contrast agents furnished on and after January 1, 2010, when a contrast-enhanced procedure that is assigned to a procedural APC with a “policy-packaged” drug amount greater than \$20 (that is not an APC containing nuclear medicine



procedures) is billed on the same claim with a pass-through contrast agent on the same date of service, CMS will reduce the amount of payment for the contrast agent by

the corresponding contrast-enhanced procedure’s portion of its APC payment associated with “policy-packaged” drugs (offset amount) so that no duplicate contrast agent payment is made.

CY 2010 procedural APCs for which CMS expects a contrast agent payment offset could be applicable in the case of a pass-through contrast agent are identified in the table following this section. Pass-through payment for a contrast agent is the difference between the payment for the pass-through product and the payment for the predecessor product that, in the case of a contrast agent, is packaged into the payment for the contrast-enhanced procedure in which the contrast agent is used.

Effective January 1, 2009, contrast agent HCPCS code C9246 (Injection, gadoxetate disodium, per ml) was granted pass-through status under the OPPS and was assigned status indicator “G”. As the pass-through offset methodology was not in place for contrast agents in CY 2009, payments for HCPCS code C9246 were not reduced by the corresponding contrast-enhanced procedure’s portion of its APC payment associated with “policy-packaged” drugs (offset amount).

For CY 2010, HCPCS code C9246 is being replaced with HCPCS code A9581 (Injection, gadoxetate disodium, 1 ml) and HCPCS code A9581 will continue on pass-through status for CY 2010. In addition, HCPCS code A9583 (Injection, gadofosveset trisodium, 1 ml) describes a contrast agent that has been granted pass-through status beginning January 1, 2010. Both HCPCS codes A9581 and A9583 will be assigned status indicator “G” and will be subject to the payment offset methodology for contrast agents. Therefore, in CY 2010 CMS will reduce the payment for HCPCS codes A9581 and A9583 by the estimated amount of payment that is attributable to the predecessor contrast agent that is packaged into payment for the associated contrast-enhanced procedure reported on the same claim on the same date as HCPCS code A9581 or A9583 if the contrast-enhanced procedure is assigned to one of the APCs listed in the table below. The “policy-packaged” portions of the CY 2010 APC payments that are the offset amounts may be found on the CMS website at <http://www.cms.hhs.gov/HospitalOutpatientPPS/APF/list.asp#TopOfPage> in the download file labeled 2010 OPPS Offset Amounts by APC.

APCs to Which a Pass-Through Contrast Agent Offset May Be Applicable for CY 2010

CY 2010 APC	CY 2010 APC Title
0080	Diagnostic Cardiac Catheterization
0082	Coronary or Non-Coronary Atherectomy
0083	Coronary or Non-Coronary Angioplasty and Percutaneous Valvuloplasty
0093	Vascular Reconstruction/Fistula Repair without Device
0104	Transcatheter Placement of Intracoronary Stents
0128	Echocardiogram with Contrast
0152	Level I Percutaneous Abdominal and Biliary Procedures
0229	Transcatheter Placement of Intravascular Shunts
0278	Diagnostic Urography
0279	Level II Angiography and Venography
0280	Level III Angiography and Venography
0283	Computed Tomography with Contrast
0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contrast
0333	Computed Tomography without Contrast followed by Contrast
0337	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Contrast followed by Contrast
0375	Ancillary Outpatient Services When Patient Expires
0383	Cardiac Computed Tomographic Imaging
0388	Discography
0418	Insertion of Left Ventricular Pacing Elect.
0442	Dosimetric Drug Administration
0653	Vascular Reconstruction/Fistula Repair with Device
0656	Transcatheter Placement of Intracoronary Drug-Eluting Stents
0662	CT Angiography
0668	Level I Angiography and Venography
8006	CT and CTA with Contrast Composite
8008	MRI and MRA with Contrast Composite

Drug Administration Services

Drug administration services will continue to be reported using the full set of drug administration CPT codes with the following exception. CMS instructs that new CPT code 90470 [H1N1 immunization administration (intramuscular, intranasal), including counseling when performed] created by the AMA for administration of the H1N1 vaccine for CY 2010 should not be reported. It is assigned status indicator

“E” for OPPS payment purposes in CY 2010. Hospitals that administer the H1N1 vaccine should continue to use HCPCS code G9141 (Influenza A (H1N1) drug administration (includes the physician counseling the patient/family) for services furnished on or after September 1, 2009. Further information related to H1N1 codes can be found in Transmittal 547, CR 6633, issued August 28, 2009.

Edit Changes in 2010

There are significant edit changes implemented by Medicare on January 1st that should be noted. They are described on the following page by type of edit.

Medically Unlikely Edits (MUEs)

Three procedures have their MUEs increased in 2010:

- 74424 – Antegrade Urography S&I is increased to 2
- 75726 – Visceral angiography S&I is increased to 3
- 75736 – Selective pelvic angiography S&I is increased to 2

ZHealth was instrumental in facilitating these changes. Edits are revised when there is sufficient supporting information as to why and edit does not follow coding guidelines.

National Correct Coding Initiative (NCCI) Edits

The following NCCI edits have been revised effective January 1 for physicians and April 1 for hospitals. Hospitals must abide by coding rules even when an edit isn't in effect.

- Unilateral sacroplasty (202T) is added as a "1" edit with lumbar vertebroplasty (22524).
- Chest tube fibrinolysis (32561 and 32562) is added as a "1" edit (mutually exclusive) with insertion of a tunneled pleural catheter (32550).
- Angioplasty codes are added as "1" edits with atherectomy procedure codes [e.g., open (35454) and percutaneous iliac (35473) angioplasties are "1" edits with open and percutaneous iliac atherectomies (35482 and 35492)].
- AV dialysis shunt imaging and access (36147) is added as a "1" edit with AV fistula thrombectomy without revision (36831) and external cannula declotting (36860 and 36861).
- Intraoperative ultrasound guidance (76998), fluoroscopy (76000 and 76001), and fluoroscopic guidance for needle placement (77002) are now "1" edits with almost all pain procedures. (Code 77003 is the appropriate code to use for fluoroscopic guidance.)
- Re-programming of an implantable cardiac defibrillator (ICD) (93287) and interrogation of an ICD (93296) are now "1" edits with internal cardioversion (92961).
- Electrophysiology (EP) codes 93602, 93603, 93610, 93612, 93618, 93619, 93620, 93621, 93622, and 93623 are "0" edits with AV node ablation (93650).
- EP codes 93610 and 93612 are "0" edits with supraventricular tachycardia ablation (93651).
- EP codes 93600, 93602, 93603, 93610, 93612, and 93618 are "0" edits with ventricular tachycardia ablation (93652).

Edits are confined to performance at the same site and or during the same encounter. Modifier -59 can be utilized on "1" edits when a distinct procedure is performed. "0" edits cannot be bypassed. The codes will never be reimbursed when on the same claim as the Column 1 (comprehensive) code.

Misuse of Modifiers -PA, -PB, and -PC

Effective January 15, 2009, the Centers for Medicare & Medicaid Services (CMS) does not cover a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs: 1) a different procedure altogether, 2) the correct procedure but on the wrong body part, or 3) the correct procedure but on the wrong patient.

Providers are required to append one of the following applicable modifiers to all lines related to the erroneous surgery(s) with dates of service on or after January 15, 2009:

- PA: Surgery Wrong Body Part
- PB: Surgery Wrong Patient
- PC: Wrong Surgery on Patient

CMS has learned that these modifiers are, in many cases, being submitted incorrectly by providers.

In particular, some providers are using the -PC modifier to represent the professional component of a service. This is incorrect. The -PC modifier is defined as "Wrong Surgery on a Patient". The incorrect use of this modifier results in claims being incorrectly denied. Medicare contractors will follow new guidelines to help prevent claims from being processed with modifiers incorrectly submitted on them.

Medicare contractors will:

- Suspend, review, and develop all claim lines that are submitted with the -PA, -PB, or -PC modifiers; and
- Contact the provider to determine whether the claims are related to one of the adverse events as described by the modifiers -PA, -PB, or -PC.

If the contractor determines that

the modifiers -PA, -PB, or -PC have been incorrectly submitted, they will:

- Reject (return to provider) Part A outpatient claims;
- Return Part B claims as unprocessable with;
 - » Claim Adjustment reason Code 4 (The procedure code is inconsistent with the modifier used or a required modifier is miss-

ing.); and

- » Remittance advice Remark Code MA130 – Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

Revisions to SNF Consolidated Billing

CMS recently updated the Skilled Nursing Facility (SNF) consolidated billing files to reflect new codes that have been developed for 2010 and codes that have been discontinued for 2010. In addition, the files reflect any additions and deletions to services excluded from consolidated billing. These files are effective for claims with dates of service on or after 1/01/2010 unless otherwise noted. Following are the changes to the files (physician services are not part of consolidated billing):

Major Category I.C. – Magnetic Resonance Imaging (MRI)

(These services are exempt from consolidated billing and can be billed separately by a hospital.)

ADD – 75557, 75558, 75559, 75560, 75561, 75562, 75563 and 75564

REMOVE – 75552, 75553, 75554, and 75555

Major Category I.D. – Radiation Therapy

(These services are exempt from consolidated billing and can be billed separately by a hospital.)

ADD – A9527, C2639, C2641 and C2643

REMOVE – C1718, C1720 2632 and C2633

Major Category I.F. – Outpatient Surgery and Related Procedures

(These services are exempt from consolidated billing and can be billed separately by a hospital.)

ADD – 32550 and 32551

REMOVE – 32019, 32020, 36540 and 36550

Major Category III. A. – Chemotherapy

(These services are exempt from consolidated billing and can be billed separately by a hospital.)

ADD – J9171 and J9328

REMOVE – J9170

Major Category III.B. – Chemotherapy Administration

(These services are exempt from consolidated billing and can be billed separately by a hospital.)

REMOVE – C8953, C8954 and C8955

Major Category III.D – Customized Prosthetic Devices

(These services are exempt from consolidated billing and can be billed separately by a hospital.)

ADD – L5973

REMOVE – L6639

Major Category V. A. – Therapies

(Therapy services are included in SNF PPS and consolidated billing for residents in a Part A stay, and must be billed by the SNF alone for its Part B residents and non-residents.)

ADD – 92520

Instructions Regarding Processing Claims Rejecting for Gender/Procedure Conflict

A revised transmittal was published on December 18, 2009 and is effective April 1, 2010 that provides instructions for completing Part A and Part B claims for gender specific services for beneficiaries who are transgender, hermaphrodites, or have ambiguous genitalia.

Claims for some beneficiaries are being rejected by Medicare systems due to gender specific edits, and results in inappropriate denials for claims. For Part

"Physicians and non-physician practitioners are instructed that, for Part B professional claims, the -KX modifier...should be billed on the detail line with any procedure code(s) that are gender specific for the affected beneficiaries."

A claims processing, institutional providers should report condition code 45 (Ambiguous

Gender Category) on inpatient or outpatient services that can be subjected to gender specific editing (i.e., services that are considered female or male only) for the above defined beneficiaries. Physicians and non-physician practitioners are instructed that, for Part B professional claims, the -KX modifier (Requirements specified in the medical policy have been met) should be billed on the detail line with any procedure code(s) that are gender specific for the affected beneficiaries. Use of the -KX modifier will alert the carrier/MAC that the physician/practitioner is performing a service on a patient for whom gender specific editing may apply, and that the service should be allowed to continue with normal processing. Payment will be made if the coverage and reporting criteria have been met for the service.

CMS and ONC Issue Regulations Proposing a Definition of "Meaningful Use" and Setting Standards for Electronic Health Record Incentive Program

The Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) encourage public comment on two regulations issued on 12/30/2009 that lay a foundation for improving quality, efficiency, and safety through meaningful use of certified electronic health record (EHR) technology.

The full press release is included below for your convenience:

FOR IMMEDIATE RELEASE

Contact: HHS Press Office
Wednesday, December 30, 2009
(202) 690-6343

CMS and ONC Issue Regulations Proposing a Definition of "Meaningful Use" and Setting Standards for Electronic Health Record Incentive Program Public Encouraged to Comment on New Regulations

The Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) encourage public comment on two regulations issued recently that lay a foundation for improving quality, efficiency, and safety through meaningful use of certified electronic health record (EHR) technology. The regulations will help implement the EHR incentive programs enacted under the American Recovery and Reinvestment Act of 2009 (Recovery Act).

A proposed rule issued by CMS outlines proposed provisions governing the EHR incentive programs, including defining the central concept of "meaningful use" of EHR technology. An interim final regulation (IFR) issued by ONC sets initial standards, implementation specifications, and certification criteria for EHR technology. Both regulations are open to public comment.

"Widespread adoption of electronic health records holds great promise for improving health care quality, efficiency, and patient safety," said National Coordinator for Health Information Technology David Blumenthal, M.D., M.P.P. "The Recovery Act's financial incentives demonstrate Congress' and the Administration's commitment to help providers adopt and make meaningful use of EHR

"An interim final regulation (IFR) issued by ONC sets initial standards, implementation specifications, and certification criteria for EHR technology. Both regulations are open to public comment."

technology so they can give better care and their patients' experience of care will improve. Over time, we believe the EHR incentive program under Medicare and Medicaid will accelerate and facilitate health information technology adoption by more individual providers and organizations throughout the health care system."

"These regulations are closely linked," said Charlene Frizzera, CMS Acting Administrator. "CMS's proposed regulation would define and specify how to demonstrate 'meaningful use' of EHR technology, which is a prerequisite for receiving the Medicare incentive payments. Our rule also outlines the proposed payment methodologies for the Medicare and Medicaid EHR incentive programs. ONC's regulation sets forth the standards and specifications that will enhance the interoperability, functionality, utility, and security of health information technology."

CMS and ONC worked closely to develop the two rules and received input from hundreds of technical subject matters experts, health care providers, and other key stakeholders. Numerous public meetings to solicit public comment were held by three Federal

advisory committees: the National Committee on Vital and Health Statistics (NCVHS), the Health IT Policy Committee (HITPC), and the Health IT Standards Committee (HITSC). HITSC presented its final recommendations to the National Coordinator in August 2009. These recommendations, along with all other input, were considered to help inform the development of the regulations announced today.

The IFR issued by ONC describes the standards that must be met by certified EHR technology to exchange healthcare information among providers and between providers and patients. This initial set of standards begins to define a common language to ensure accurate and secure health information exchange across different EHR systems. The IFR describes standard formats for clinical summaries and prescriptions; standard terms to describe clinical problems, procedures, laboratory tests, medications, and allergies; and standards for the secure transportation of this information using the Internet.

The IFR calls for the industry to standardize the way in which EHR information is exchanged between organizations, and sets forth criteria required for an EHR technology to be certified. These standards will support meaningful use and data exchange among providers who must use certified EHR technology to qualify for the Medicare and Medicaid incentives.

Under the statute, HHS is required to adopt an initial set of standards for EHR technology by Dec. 31, 2009. The IFR will go into effect 30 days after publication, with an

opportunity for public comment and refinement over the next sixty days. A final rule will be issued in 2010. "We strongly encourage stakeholders to provide comments on these standards and specifications," Dr. Blumenthal said.

The Recovery Act established programs to provide incentive payments to eligible professionals and eligible hospitals participating in Medicare and Medicaid that adopt and make "meaningful use" of certified EHR technology. Incentive payments may begin as soon as October 2010 to eligible hospitals. Incentive payments to other eligible providers may begin in January 2011.

The proposed rule would define the term "meaningful EHR user" as an eligible professional or eligible hospital that, during the specified reporting period, demonstrates meaningful use of certified EHR technology in a form and manner consistent with certain objectives and measures presented in the regulation. These objectives and measures would include use of certified EHR technology in a manner that improves quality, safety, and efficiency of health care delivery; reduces health care disparities; engages patients and families; improves care coordination; improves population and public health; and ensures adequate privacy and security protections for personal health information.

The proposed rule would define meaningful use for the Medicare EHR incentive programs. It proposes one definition that would apply to eligible professionals participating in the Medicare fee-for-service and the Medicare Advan-



tage EHR incentive programs, as well as a proposed definition that would apply to eligible hospitals and critical access hospitals. These definitions also would serve as the minimum standard for eligible professionals and eligible hospitals participating in the Medicaid EHR incentive program. The rule proposes that states could request CMS approval to implement additional meaningful use measures, as appropriate, but could not request approval of fewer or less rigorous meaningful use measures than required by the rule.

This rule proposes a phased approach to implement the proposed requirements for demonstrating meaningful use. This approach would initially establish reasonable criteria for meaningful use based on currently available technological capabilities and providers' practice experience. CMS will establish stricter and more extensive criteria for demonstrat-

ing meaningful use over time, as anticipated developments in technology and providers' capabilities occur.

CMS provides a sixty-day comment period on the proposed rule. "The definition and requirements for demonstrating meaningful use of EHR technology are proposals. CMS welcomes and will give serious consideration to comments that improve our proposal while achieving the goals Congress established for the EHR incentive programs," Frizzera said.

The CMS proposed rule and fact sheets may be viewed at http://www.cms.hhs.gov/Recovery/11_HealthIT.asp

ONC's interim final rule may be viewed at <http://healthit.hhs.gov/standardsandcertification>. In early 2010 ONC intends to issue a notice of proposed rulemaking related to the certification of health informa-

tion technology.

Additional Website resources:

The Recovery Act Health IT Page is: http://www.cms.hhs.gov/Recovery/11_HealthIT.asp

DIRECT Link to CMS Regulation: http://www.federalregister.gov/OFRUpload/OFRDatta/2009-31217_PI.pdf

A copy of the ONC Regulation is available at: <http://healthit.hhs.gov/standardandsandcertification>

The HHS Press Release is available at: https://www.cms.hhs.gov/apps/media/press_releases.asp

The CMS Fact Sheets are available at: https://www.cms.hhs.gov/apps/media/fact_sheets.asp

The Next CMS Hospital & Hospital Quality Open Door Forum Scheduled for:

Date: Thursday, January 14, 2010
Start Time: 2:00 PM Eastern Time (ET)

Please dial-in at least 15 minutes before call start time.
Conference Leaders: Marc Hartstein, Mark Levine, M.D., Natalie Highsmith.

Open Door Participation Instructions:
This call is Conference Call Only

To participate by phone:
Dial: 1-800-837-1935 & Reference Conference ID: 45211596

Persons participating by phone do not need to RSVP.
TTY Communications Relay Services are available for

the Hearing Impaired. For TTY services dial 7-1-1 or 1-800-855-2880. A Relay Communications Assistant will help.

Encore: 1-800-642-1687; Conference ID# 45211596

Encore is an audio recording of this call that can be accessed by dialing 1-800-642-1687 and entering the Conference ID. This recording will be accessible beginning Tuesday, January 19, 2010 and expires after three business days.

For ODF schedule updates, E-Mailing List registration and Frequently Asked Questions, visit their website at <http://www.cms.hhs.gov/OpenDoorForums/>.

FROM THE AMERICAN MEDICAL ASSOCIATION (AMA)

In *CPT Assistant*, November 2009, the AMA instructed to use code 33999, *Unlisted procedure, cardiac surgery*, to report a percutaneous left ventricular assist device inserted and removed during stenting of a coronary artery.

The December 2009 *CPT Assistant* had several guidelines that should be applied when coding.

1. Code 19296, *Placement of radiotherapy afterload- ing expandable catheter (single or multichannel) into the breast for interstitial radioelement applica- tion following partial mastectomy, includes imag- ing guidance; on date separate from partial mas- tectomy*, should be reported for an exchange of a mastectomy cavity evaluation device for a radio- therapy afterloading balloon catheter when per- formed on a separate date from the mastectomy.
2. The removal of a indwelling tunneled pleural catheter with cuff is only reported by the physi- cian that placed the catheter. If the catheter is re- moved by another physician, it is included in that physician's evaluation and management (E&M) service.
3. Code 36593, *Dec clotting by thrombolytic agent of implanted vascular access device or catheter*, can be reported multiple times in one day when performed more than once. The declots must be separate sessions and not just be sequential administration of tPA during the same episode of care. Code 36593 should not be used for routine flushing of a central venous access device with saline or heparin.
4. A venous access device with a port is always cod- ed as a tunneled catheter with a port. "It is not procedurally possible to insert a catheter with a port attached in a manner that is **not** tunneled."
5. Unlisted nervous system procedure code 64499 should be used to report sacroiliac joint rhizot- omy when performed with a single electrode having three contacts positioned adjacent to the S1, S2, S3, and S4 lateral branch innervation path- ways through one access site. Do not report code 64622 unless the rhizotomy is performed individ- ually at each sacral level. Code 64622 would be reported one time for each level when performed as independent procedures.
6. Fluoroscopic guidance for needle placement (77002) is included in all cystourethroscopy codes and cannot be reported separately.

FROM THE AMERICAN HOSPITAL ASSOCIATION (AHA)

In *AHA Coding Clinic for HCPCS* Third Quarter 2009 the following coding instructions for hospital billing were given:

- If intraoperative MRI guidance is provided for an intracranial procedure that is not an open procedure report code 77021, *Magnetic resonance guidance for needle placement (eg, for biopsy, needle aspiration, in- jection, or placement of localization device) radiological supervision and interpretation*. Do not report codes 70557 – 70559 for a procedure that is not an open procedure.
- To report fluoroscopically-guided Lap Band adjustment, report code 77002, *Fluoroscopic guidance for nee- dle placement (eg, biopsy, aspiration, injection, localization device)*. An additional code is not reported for the injection procedure. If fluoroscopic guidance isn't utilized, it is an E&M procedure.
- Do not report additional codes for performance of an acetylcholine (Ach) challenge test performed dur- ing cardiac catheterization. It is included in the cardiac catheterization procedure.
- Do not report administration of nitric oxide during a right heart catheterization to measure pressure in the pulmonary arteries separately. It is included in the right heart catheterization.
- Code 62311, *Injection, single (not via indwelling catheter), not including neurolytic substances, with or with- out contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including an- esthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal)*, is reported only one time per date of service regardless of the number of lumbar injections performed.
- Placement of a tunneled central catheter to perform hypothermia via injection of cold saline through

the catheter should be reported as placement of any other central catheter, with code 36558, *Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; age 5 years or older.*

FROM THE AMERICAN COLLEGE OF RADIOLOGY (ACR) Physician Payment Cut Delayed

Based on the 2010 Medicare fee schedule final rule, the 21.2 percent cut to the conversion factor was scheduled to be implemented Jan. 1, 2010. However, as of December 19, 2009, Congress has passed legislation to apply a zero percent update to the conversion factor through Feb. 28, 2010. This means that instead of the 21.2 cut, the conversion factor for January and February 2010 will be the same as 2009. Below is information from CMS on how claims will be handled for the first ten business days in January to ensure correct payments to physicians.

Information Regarding the Holding of Claims for Services Paid Under the 2010 Medicare Physician Fee Schedule

The Centers for Medicare & Medicaid Services (CMS) is working with Congress, health care providers, and the beneficiary community to avoid disruption in the delivery of health care services and payment of claims for physicians, non-physician practitioners, and other providers of services paid under the Medicare physician fee schedule, beginning Jan. 1, 2010. In this regard, CMS has instructed its contractors to hold claims for services paid under the Medicare Physician Fee Schedule (MPFS) for up to the first ten business days of January (January 1 through January 15) for 2010 dates of service. This should have minimum impact on provider cash flow because, by law, clean electronic claims are not paid any sooner than

fourteen calendar days (twenty-nine days for paper claims) after the date of receipt. Meanwhile, all claims for services delivered on or before Dec. 31, 2009 will be processed and paid under normal procedures.

The holding of claims allows Medicare contractors time to receive the new, updated payment files and perform necessary testing before paying claims at the new rates. CMS has instructed contractors to begin processing claims at the new rates **no later than** Jan. 19, 2010. Please note that most contractors are closed on the January 18 Martin Luther King Day holiday. Therefore, even absent a new update, most claims likely would not have been paid any sooner than Jan. 19, 2010, given the aforementioned statutory fourteen-day payment floor.

CMS has extended the 2010 Annual Participation Enrollment Program end date from Jan. 31, 2010, to **March 17, 2010** - therefore, the enrollment period now runs from Nov. 13, 2009 through March 17, 2010. The effective date for any Participation status change during the extension, however, remains Jan. 1, 2010 and will be in force for the entire year.

Contractors will accept and process any Participation elections or withdrawals made during the extended enrollment period that are received or post-marked on or before March 17, 2010.

ACR Statement on Airport Full-Body Scanners and Radiation

January 2010 - Amid concerns regarding terrorists targeting airliners using weapons less detectable by traditional means, the Transportation Security Administration (TSA) is ramping up deployment of whole body scanners at security checkpoints in U.S. airports. These systems produce anatomically accurate images of the body and can detect objects and substances concealed by clothing.

To date, TSA has deployed two types of scanning systems:

Millimeter wave technology uses low-level radio waves in the millimeter wave spectrum. Two rotating antennae cover the passenger from head to toe with low-level RF energy.

Backscatter technology uses extremely weak X-rays delivering

less than 10 microRem of radiation per scan - the radiation equivalent one receives inside an aircraft flying for two minutes at 30,000 feet. An airline passenger flying cross-country is exposed to more radiation from the flight than from screening by one of these devices. The National Council on Radiation Protection and Measurement (NCRP) has reported that a traveler would need to experience

100 backscatter scans per year to reach what they classify as a Negligible Individual Dose. The American College of Radiology (ACR) agrees with this conclusion. By these measurements, a traveler would require more than 1,000 such scans in a year to reach the effective dose equal to one stan-

dard chest x-ray.

The ACR is not aware of any evidence that either of the scanning technologies that the TSA is considering would present significant biological effects for passengers screened.

The ACR encourages those interested in learning more regarding radiation associated with imaging and radiation oncology procedures as well as radiation naturally occurring in the Earth's atmosphere to visit www.radiologyinfo.org.

FROM THE SOCIETY OF INTERVENTIONAL RADIOLOGY (SIR)

Instead of publishing a 2010 Coding Guide Book, the SIR has published a 2010 "Coding Users' Guide Online Supplement". The supplement only discusses 2010 code changes and is to be used in conjunction with the 2009 "Coding User's Guide". It is only available in an electronic format and is available for purchase and download on the SIR website.

U.S. Food and Drug Administration Issues Several Alerts

The U.S. Food and Drug Administration (FDA) has announced the following product recalls:

- [Cardiovascular Systems, Inc., ViperSheath Sheath Introducer](#): Fractures may occur during use. If this occurs, patients may need unplanned surgery to remove the fragments or to control bleeding.
- [ev3 Endovascular, Inc., Trail-](#)

[blazer Support Catheter](#): This device may crack near the radiopaque marker band. This may result in serious patient injury, including insufficient oxygen supply to the tissues, damage to blood vessels, heart attack, limb amputation, unplanned surgery, and/or death.

The FDA has also issued an update on its [safety investigation on CT](#)

[brain perfusion scans](#). The investigation has determined that, while unnecessary radiation exposure should be avoided, the benefits of a medically needed CT scan outweigh the radiation risks. The FDA also provides in this update a series of recommendations for facilities and practitioners designed to enhance radiation safety measures.

FROM NATIONAL GOVERNMENT SERVICES MEDICARE ADMINISTRATIVE CONTRACTOR - PART A

Local Coverage Determination (LCD) Update

Cardiac Computed Tomography (CCT) and Coronary Computed Tomography Angiography (CCTA)—LCD (L25907)

R5 (effective 01/01/2010): Annual HCPCS code update for 2010: CPT codes 0144T-0151T have been deleted and replaced by codes 75571-75574 effective 01/01/2010. Information added on bill type for reporting FQHC services. Minor formatting changes made. No comment or notice periods required and none given.

Cardiac Computed Tomography (CCT) and Coronary Computed Tomography Angiography (CCTA) SIA (A45020)

Article published January 2010: Annual HCPCS code update for 2010: CPT codes 0144T-0151T have been deleted and replaced by codes 75571-75574 effective 01/01/2010. Place of service information revised to include federally qualified health center (50) and rural health clinic (72) for technical component services. Information added on bill type for reporting FQHC services. Low osmolar contrast codes updated to replace HCPCS Q9945-Q9950 with codes Q9965-Q9967, effective 01/01/2008. Minor formatting changes made.

Cardiac Event Detection SIA (A45929)

Article published 01/01/2010: Coding updated to accommodate availability of new type of monitoring device. Instructions for billing of new telemetry device with not greater than 24 hours accessible ECG data storage was added to specify the use and reimbursement of code 93799-26 for interpretation and report, and code 93799-TC for hook-up. Place of service information updated to remove POS 12, 13, 14, 32 for CPT 93012, 93228, to remove POS 31, 32 for CPT 93014, 93272, 93799-26, to remove POS 12, 13, 14, 32, 33 for CPT 93229, to remove POS 13, 32, 33 for CPT 93268, to remove POS 32 for CPT 93270 and to add POS 50 and 72 for CPT 93271 and add POS 11, 33, 49, 50 and 72 for CPT 93799-TC. Minor formatting changes made.

Cardiovascular Nuclear Medicine—LCD (L26859)

R6 (effective 01/01/2010): LCD revised for annual HCPCS update to add CPT codes 78451-78454, as replacements for CPT codes 78460, 78461, 78464, 78465, 78478, and 78480; to revise HCPCS code A9500 descriptor. Minor formatting changes made. No comment and notice periods required and none given.

Cardiovascular Nuclear Medicine SIA (A46181)

Article published January 2010: Annual HCPCS update added CPT codes 78451-78454 to coding instructions, as replacements for CPT codes 78460, 78461, 78464, 78465, 78478, and 78480; coding combination restrictions based on the new CPT code descriptors for codes 78451-78454 were identified; revised HCPCS code A9500 descriptor.

Computed Tomographic (CT) Colonography—LCD (L25233)

R4 (effective 01/01/2010): LCD revised for annual HCPCS update for 2010. Revised the section headings for the CMS Publications listed in the “CMS National Coverage Policy” section to align with the Internet- Only Manuals (IOMs). The reference to CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 13, Section 30, was removed as it addresses IV contrast, not the contrast enema.

CPT code 0066T was deleted 12/31/2009. CPT code 74263 was added as the replacement code. The following limitation was revised:

CPT code 74263 (CPT code 0066T for dates of service prior to January 1, 2010) is a noncovered service, and is Status Indicator “N” on the Medicare Physician Fee Schedule Database (MPFSDB). CT colonography is not reimbursable when performed for screening purposes, regardless of whether billed with CPT codes 74261, 74262 or 74263 (CPT codes 0066T or 0067T for dates of service prior to January 1, 2010) or any other HCPCS/ CPT code.

CPT code 0067T was deleted 12/31/2009 and removed from the listing in the “CPT/HCPCS Codes” section of the LCD. An explanatory note regarding the code deletion was added to this section. CPT codes 74261 and 74262 were added as the replacement codes. CPT code 0066T was deleted from the “CPT/HCPCS Codes” section as a result of a prior revision. This code was added to the explanatory note. CPT code 74263 was added as the replacement code.

Minor template changes were made to reflect current template language. No comment and notice periods required and none given.

Computed Tomographic (CT) Colonography SIA (A44376)

Article published January 2010: SIA revised for annual HCPCS update for 2010. CPT code 0066T was deleted 12/31/2009. CPT code 74263 was added as the replacement code. The following carrier or fiscal intermediary or Part A or Part B MAC coding guidelines were revised:

CPT code 74263 (CPT code 0066T for dates of service prior to January 1, 2010) is a noncovered service, and is Status Indicator “N” on the Medicare Physician Fee Schedule Database (MPFSDB). CT colonography is not reimbursable when performed for screening purposes, regardless of whether billed with CPT codes 74261, 74262 or 74263 (CPT codes 0066T or 0067T for dates of service prior to January 1, 2010) or any other HCPCS/ CPT code.

CPT code 74261 or 74262 (or CPT codes 0067T for dates of service prior to January 1, 2010) must not be reported in conjunction with CPT codes 72192-72194, 74150-74170 or 76376-76377.

Added the following carrier or Part B MAC coding guideline as payable places of service under Medicare Part B:

For the technical component (modifier TC): federally qualified health center (50) and rural health clinic (72)

Added the place of service for an urgent care facility (20) and a public health clinic (71) to the following carrier or Part B MAC coding guideline as payable under Medicare Part B:

For the professional component (modifier 26): office (11), inpatient hospital (21), outpatient hospital (22), hospital emergency room (23), independent clinic (49) and public health clinic (71)

CPT code 0067T was deleted 12/31/2009 and removed from the listing in the "CPT/HCPCS Codes" section of the SIA. An explanatory note regarding the code deletion was added to this section. CPT codes 74261 and 74262 were added as the replacement codes. CPT code 0066T was deleted from the "CPT/HCPCS Codes" section as a result of a prior revision. This code was added to the explanatory note. CPT code 74263 was added as the replacement code.

Minor template changes were made to reflect current template language.

Non-Invasive Vascular Studies—LCD (L27355)

R4 (effective 01/01/2010): Source of Revision: Reconsideration Request—The indications for Transcranial Doppler (TCD) Studies (93886-93893) were updated to include: "As an alternative to an echocardiogram to detect residual right to left shunting after repair/closure of an intracardiac or intrapulmonary shunt." The ICD-9 coding list for Cerebrovascular Evaluation (93886, 93888, 93890, 93892, 93893) was updated to add V58.73 (AFTERCARE FOLLOWING SURGERY OF THE CIRCULATORY SYSTEM NOT ELSEWHERE CLASSIFIED) to the list of covered indications. The Sources of Information were updated to add literature to support the reconsideration request.

Based on CR 6338, Change Type of Bill (TOB) for Federally Qualified Health Centers (FQHCs) from 73X to 77X, the following paragraph has been added to the "Other Comments" section of the LCD: "For dates of service prior to April 1, 2010, FQHC services should be reported with bill type 73X. For dates of service on or after April 1, 2010, bill type 77X should be used to report FQHC services." Minor changes were made to reflect current template language. No comment period required and none given. The SIA associated with this policy was similarly updated.

Non-Invasive Vascular Studies SIA (A47394)

Article published January 2010: Based on CR 6338, Change Type of Bill (TOB) for Federally Qualified Health Centers (FQHCs) from 73X to 77X, the following paragraph has been added to the SIA: "For dates of service prior to April 1, 2010, FQHC services should be reported with bill type 73X. For dates of service on or after April 1, 2010, bill type 77X should be used to report FQHC services." Minor changes were made to reflect current template language. The local coverage determination associated with this policy was similarly updated.

Pain Management—LCD (L28529)

R3 (effective date 01/01/2010): Source of Revision—CPT/HCPCS Coding Update 2010—CPT codes 64470, 64472 were deleted from group 4 (PARAVERTEBRAL JOINT/NERVE BLOCKS – DIAGNOSTIC AND THERAPEUTIC) and replaced with CPT codes 64490, 64491, 64492. CPT codes 64475, 64476 were deleted from group 4 (PARAVERTEBRAL JOINT/NERVE BLOCKS – DIAGNOSTIC AND THERAPEUTIC) and replaced with CPT codes 64493,

64494, 64495. The code descriptor was changed for CPT code 77003. The LCD was updated throughout to remove references to deleted codes and update for new codes.

The following guideline was added to the Indications for Paravertebral Facet Joint/Nerve Block: "Image guidance and localization are required for the performance of paravertebral facet joint injections described by codes 64490-64495. For Paravertebral Spinal Nerves and Branches—Fluoroscopic or computed tomography (CT) image guidance [fluoroscopy or CT] and any injection of contrast are inclusive components of 64490-64495."

Based on CR 6338, Change Type of Bill (TOB) for Federally Qualified Health Centers (FQHCs) from 73X to 77X, the following paragraph has been added to the "Other Comments" section of the LCD: "For dates of service prior to April 1, 2010, FQHC services should be reported with bill type 73X. For dates of service on or after April 1, 2010, bill type 77X should be used to report FQHC services."

Minor changes were made to reflect current template language. No comment period required and none given. The SIA associated with this policy was similarly updated.

Pain Management SIA (A48042)

Article published January 2010: Source of revision—CPT/HCPCS Coding Update 2010: CPT codes 64470, 64472 were deleted from group 4 (PARAVERTEBRAL JOINT/NERVE BLOCKS--DIAGNOSTIC AND THERAPEUTIC) and replaced with CPT codes 64490, 64491 and 64492. CPT codes 64475, 64476 were deleted from group 4 (PARAVERTEBRAL JOINT/NERVE BLOCKS—DIAGNOSTIC AND THERAPEUTIC) and replaced with CPT codes 64493, 64494 and 64495. The code descriptor was changed for CPT code 77003. The SIA was updated throughout to remove references to deleted codes and update for new codes.

Guidelines for *General Guidelines for claims submitted to Carriers or Intermediaries or Part A or Part B MAC*: were updated with the addition of the following: "Do not report CPT codes 64490–64495 unless fluoroscopic or CT guidance is performed." and "For Paravertebral Spinal Nerves and Branches—Image guidance [fluoroscopy or CT] and any injection of contrast are inclusive components of 64490-64495."

Coding instructions for Paravertebral Joint/Nerve Blocks—Diagnostic and Therapeutic were updated with the addition of the following: "Use CPT codes 64491 and 64492 in conjunction with 64490. Do not report CPT code 64492 more than once per day. Use CPT codes 64494 and 64495 in conjunction with 64493. Do not report CPT code 64495 more than once per day. For injection of the T12-L1 joint or nerves innervating that joint, use 64493."

Coding instructions for Interlaminar or Caudal Epidural and/or Intrathecal Injections Including Those Treating Spasticity, Transforaminal Epidural Injections, Paravertebral Joint/Nerve Injections and Denervation, and Sacroiliac Joint Injections were updated with the addition of the following statement: CPT code G0260 may only be billed in the ambulatory surgery center (ASC)—POS 24. The -KX modifier instructions were updated as follows: "Ambulatory surgery centers must append modifier -KX (Requirements in the medical policy have been met) to all procedures for which fluoroscopy- or CT-guidance is medically necessary to attest to the use of such imaging unless the image guidance is included in the description of the procedure code. Procedures requiring medically necessary fluoroscopy- or CT-guidance include transforaminal epidural injections, paravertebral joint/nerve injections or denervations, and sacroiliac joint injections. In addition, subsequent epidural (interlaminar or caudal) injections after a failed or inadequate response to a blind injection, if performed, should be under fluoroscopic visualization or CT-guidance. Effective January 1, 2010, modifier -KX is not required for paravertebral joint/nerve injections. However, the CPT procedures codes 64490-64495 should not be reported unless fluoroscopy or CT guidance is performed."

Based on CR 6338, Change Type of Bill (TOB) for Federally Qualified Health Centers (FQHCs) from 73X to 77X, the following paragraph has been added to the SIA: "For dates of service prior to April 1, 2010, FQHC services should be reported with bill type 73X. For dates of service on or after April 1, 2010, bill type 77X should be used to report FQHC services." Minor changes were made to reflect current template language. The local coverage determination associated with this policy was similarly updated.

Transthoracic Echocardiography (TTE)—LCD (L27360)

R4 (effective 01/01/2010): LCD revised for annual HCPCS update for 2010 to replace deleted code J0460 with code J0461 effective 01/01/2010. Information added on bill type for reporting FQHC services. Minor formatting changes made. No comment or notice periods required and none given.

Transthoracic Echocardiography (TTE) SIA (A48397)

Article published January 2010: Article revised for annual HCPCS update for 2010 to replace deleted code J0460 with code J0461 effective 01/01/2010. Information added on bill type for reporting FQHC services. Minor formatting changes made.

Varicose Veins of the Lower Extremity, Treatment of LCD (L25519)

R5 (effective 01/01/2010): LCD revised for annual HCPCS update for 2010. Based on the 2010 CPT Book, the following statement was added to the "Limitations" section:

CPT codes 37760 and 37761 should not be reported in conjunction with CPT codes 76937, 76942, 76998 or 93971.

CPT code 37761 was added to the "CPT/HCPCS Codes" section. The terminology for CPT code 37760 was revised for dates of service on or after 01/01/2009.

CPT code 37761 was added to the explanatory notes in the "ICD-9-CM Codes that Support Medical Necessity" and "ICD-9-CM Codes that DO NOT Support Medical Necessity" sections.

The following explanatory note was added to the "ICD-9-CM Codes that Support Medical Necessity" section:

Coverage of CPT codes 76942, 93965, 93970 and 93971 is not limited to the diagnoses listed below. Minor template changes were made to reflect current template language. No comment and notice periods required and none given.

Varicose Veins of the Lower Extremity, Treatment of SIA (A44614)

Article published January 2010: SIA revised for annual HCPCS update for 2010. Based on the 2010 *CPT Book*, the following carrier or fiscal intermediary or Part A or Part B MAC coding guidelines were added: For providers other than Ambulatory Surgical Centers (ASC), the appropriate site modifier (RT, LT or 50) must be appended to CPT code 37760 or 37761 to indicate if the service was performed unilaterally or bilaterally. Claims without a modifier will be returned to the provider unprocessed.

CPT codes 37760 and 37761 should not be reported in conjunction with CPT codes 76937, 76942, 76998, or 93971.

Added CPT code 37761 to the following carrier or Part B MAC coding guideline as payable places of service under Medicare Part B:

Claims for treatment of varicose veins services are payable under Medicare Part B in the following places of service: office (11); inpatient hospital (21); outpatient hospital (22), ambulatory surgical center (ASC) (24) and independent clinic (49). CPT codes 36475, 36476, 36478, 36479, 37700, 37718, 37722, 37735, 37760, 37761 and 37780 are the only procedures that qualify for an (ASC) ambulatory surgical center (24) facility fee pay-

ment.

CPT code 37761 was added to the "CPT/HCPCS Codes" section. The terminology for CPT code 37760 was revised for dates of service on or after 01/01/2009.

Minor template changes were made to reflect current template language.

Draft LCD for Draft LCD for Dialysis Shunt Maintenance (DL30737)



Please note: This is a Draft policy.

Draft LCDs are works in progress that are available on the Medicare Coverage Database site for public review. Draft LCDs are not necessarily a reflection of the current policies or practices of the contractor.



Please note: This is a Future Draft LCD.

Contractor Information

Contractor Name

[National Government Services, Inc.](#)

Contractor Number

00131

Contractor Type

FI

LCD Information

LCD ID Number

DL30737

LCD Title

Draft LCD for Dialysis Shunt Maintenance

Contractor's Determination Number

DL30737

AMA CPT / ADA CDT Copyright Statement

CPT codes, descriptions and other data only are copyright 2009 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Clauses Apply. Current Dental Terminology, (CDT) (including procedure codes, nomenclature, descriptors and other data contained therein) is copyright by the American Dental Association. © 2002, 2004 American Dental Association. All rights reserved. Applicable FARS/DFARS apply.

CMS National Coverage Policy

Language quoted from Centers for Medicare and Medicaid Services (CMS). National Coverage Determinations (NCDs) and coverage provisions in interpretive manuals is italicized throughout the policy. NCDs and coverage provisions in interpretive manuals are not subject to the Local Coverage Determination (LCD) Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See Section 1869(f)(1)(A)(i) of the Social Security Act.

Unless otherwise specified, *italicized* text represents quotation from one or more of the following CMS sources:

Title XVIII of the Social Security Act (SSA):

Section 1862(a)(1)(A) excludes expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Section 1833(e) prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

CMS Publications:

CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 11: End Stage Renal Disease (ESRD):

20.1 Noninvasive Vascular Studies for End Stage Renal Disease (ESRD) Patients

30.4.2 Separately Billable Drugs.

30.5 ESRD Composite Payment Rates

80 Physician's Services for Renal Dialysis Patients - General

CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 14: Medical Devices:

10 Coverage of Medical Devices

20 FDA Approval Investigational Device Exemptions (IDEs) 20.2 - Category B

CMS Publication 100-03, *Medicare National Coverage Determinations Manual*, Part 1:

20.7,B1 Percutaneous Transluminal Angioplasty (PTA)

20.7,D Other

Primary Geographic Jurisdiction

Illinois

Oversight Region

Region V

Projected Determination Effective Date

For services performed on or after 06/01/2010

Original Determination Ending Date

Revision Effective Date

For services performed on or after 06/01/2010

Revision Ending Date

Indications and Limitations of Coverage and/or Medical Necessity

Arteriovenous (AV) dialysis access (AV fistula, AV dialysis graft) interventions are intended to restore and/or

maintain functional patency of the AV dialysis access. These procedures encompass a number of percutaneous or open surgical procedures. Indications for interventions on an AV dialysis access include compromised flow with threatened occlusion, recent thrombosis of AV dialysis access, and management of structural abnormalities such as pseudoaneurysms. Interventions are performed on AV dialysis fistulas and grafts in order to restore adequate flow, to preserve the access' function, and avoid the need to create a new AV access. Fistulae which are not maturing as expected are also evaluated and treated with percutaneous interventions.

Percutaneous interventions to enhance or re-establish patency of a hemodialysis AV access have proven useful in extending the life of the access, reducing the need for open repair, reconstruction or replacement. The longevity and quality of life of the end stage renal dialysis (ESRD) patient are improved. This policy documents acceptable indications and limitations of coverage and other National Government Services' requirements for dialysis shunt maintenance services.

Definitions:

(AV) dialysis access: A surgically-created communication between an artery and a vein used for vascular access for hemodialysis. The communication may be a direct fistula (AV fistula) (e.g. Brescia Cimino fistula), brachiocephalic fistula or an interposed conduit (AV graft) (e.g. brachiocephalic loop graft). The conduit may be an autogenous vessel or synthetic material.

Percutaneous transluminal angioplasty (PTA): An invasive procedure which, when successful, enlarges a narrowed vascular lumen. Typically, a balloon-tipped catheter is introduced percutaneously into the narrowed vessel. The balloon is inflated at the site of vascular stenosis, stretching the vessel and opening the lumen to restore adequate flow through the vessel. The balloon is removed after angioplasty.

Thrombolysis: Pharmacologic and/or mechanical dissolution of a thrombus or blood clot.

Infusion: Continuous intravascular administration of a medication containing solution lasting longer than sixty (60) minutes. Bolus injections are not considered infusions, regardless of the time required to inject the solution.

Dialysis shunt: An arteriovenous dialysis access.

Embolization/ligation of collateral branch veins: AV fistulae depend on a single outflow vein to carry the flow, so that this vein can enlarge to the point it is easily punctured and has brisk flow. If branch veins are large enough to siphon off a significant amount of flow, no single vein will enlarge enough to be used. Closing off the side branches may allow the outflow vein to mature. The side branches may be closed off surgically by tying off the branches, or may be closed off by placement of occlusive material into the side branch through a catheter (embolization).

Indications:

Evaluation of Dialysis Shunt Dysfunction - Clinical Findings

Typically, the clinical examination provides adequate information to determine whether there is hemodynamically significant dialysis shunt dysfunction. The following clinical findings are considered diagnostically specific and appropriate indications to initiate therapies to re-establish physiologically appropriate flow in the dialysis fistula.

Venous outflow impediment clinical findings include:

- elevated venous pressure in the AV dialysis access;
- elevated venous/arterial ratio (static venous pressure ratio - above 40%);
- prolonged bleeding following needle removal;
- inefficient dialysis;
- recirculation percentage greater than 10-15%;
- development of pseudoaneurysm(s);
- swelling of the extremity, face or neck;
- development of large superficial collateral venous channels;
- loss of "machine-like" bruit, i.e., short sharp bruit; and/or
- abnormal physical findings, specifically pulsatile graft/fistula or loss of thrill.

Arterial inflow impediment clinical findings include:

- low pressure in graft even when outflow is manually occluded;
- ischemic changes of the extremity (steal syndrome); and/or
- diminished intra-access flow.

Evaluation of Dialysis Shunt Dysfunction – Diagnostic Tests

If a stenosis is suspected clinically, typically a diagnostic study is required to determine the level(s) of disease and to formulate a plan for treatment. This is most commonly accomplished with a fistulagram (CPT code 36147).

- **Diagnostic fistulagram – with puncture** of the AV dialysis access with needle or catheter placement, and diagnostic angiography of the entire AV dialysis access circuit, from the arterial anastomosis through the central veins and cava, which is performed to identify the area or areas of narrowing or occlusion that are creating flow problems for the AV dialysis access (CPT code 36147). This includes visualization and examination of the vena cava.
- **Diagnostic fistulagram - without** directly **puncturing** and/or catheterizing the AV dialysis access. For instance, a fistulagram may be performed through an existing needle or sheath or via an injection of a vessel other than direct puncture of the AV dialysis access (e.g., injection of the subclavian artery through a femoral arterial puncture) (CPT code 75791).
- **Diagnostic non-invasive vascular studies** (CPT codes 90940, 93990) performed to evaluate an AV Shunt are reasonable and necessary in the presence of signs and symptoms of impending failure of the access sites and when the result may impact the clinical course of the patient.

Percutaneous AV Dialysis Access and Maintenance

Percutaneous AV dialysis access declotting, maintenance, or re-establishment of appropriate and adequate flow may encompass any of the procedures listed below. These need not all be performed on every dysfunctional shunt, but each may, under unique circumstances, be considered reasonable and medically necessary.

Mechanical and/or pharmacologic maneuvers to promote dissolution, fragmentation and/or removal of obstructing thrombotic materials (CPT code 36870) - includes all work necessary to remove thrombus from the AV dialysis access, including mechanical thrombolysis, mechanical removal of thrombus, as well as all pharmacological means of removing thrombus from the dialysis access (including bolus, infusion, pulse-spray etc.).

Percutaneous transluminal angioplasty (PTA) - PTA of the AV dialysis access and/or afferent and efferent vessels is not necessary for all poorly functioning AV dialysis accesses. Coverage will be considered if there

is documentation supporting the presence of residual, hemodynamically significant stenosis. There must be clear documentation of the site and extent of any hemodynamically significant stenosis. This documentation may be subjected to medical necessity review.

Venous PTA – PTA is typically necessary to treat stenoses. The stenosis is most commonly found at the level of the venous anastomosis for synthetic graft accesses, but can be found anywhere from the arterial inflow through the vena cava. Multiple stenoses are found in a significant percentage of patients. When the patient presents with a thrombosed AV access, PTA is commonly needed after the acute thrombus has been removed. The AV access often occludes because of decreased flow due to an underlying narrowing, and this narrowing must be opened in order to prevent acute re-occlusion.

For purposes of reporting, the AV dialysis access is considered a single vessel from the arterial anastomosis through the axillary vein. All PTA done within this segment of vessel is coded as CPT codes 35476/75978 used once no matter how many focal lesions are treated within this segment. All PTA within the arteriovenous dialysis access “vessel” would be coded as a single PTA, regardless of the number of stenosis treated within this segment.

For AV dialysis native fistulae, the “vessel” is defined as the inflow artery at the AV anastomosis, the AV anastomosis, and the outflow vein to the level of the axillary vein. For AV dialysis grafts, the “vessel” is defined as the inflow artery at the arterial anastomosis, the arterial anastomosis, the entire length of the graft, the venous anastomosis, and the venous outflow to the level of the axillary vein. All PTA done within these defined segments would be coded as a single angioplasty.

Angioplasty may be coded a second time if a separate stenosis is treated in a central vessel (e.g., axillary, subclavian, brachiocephalic vein or artery, or SVC). The site of, and need for, separate stenosis treatment should be clearly documented. If central venous stenoses are treated, the venous angioplasty codes 35476 and 75978 should be used once to describe central venous angioplasty, even if more than one discrete central lesion must be treated.

Additionally, **arterial PTA** may be necessary if there is an inflow arterial stenosis that is limiting flow through the dialysis access. This would be coded with CPT codes 35475/75962. This is not coded for simple removal of the arterial plug when performing a declot procedure.

Open Surgical AV Dialysis Access and Maintenance

- **Open surgical therapy for thrombosed or impaired AV** dialysis access utilizes direct open access to the conduit and contiguous vessels. Mechanical fragmentation and surgical removal of occlusive thrombotic material is effected under direct visualization. Adjunctive thrombolytic pharmacotherapy may be employed. Residual vascular stenoses or obstructive lesions are removed and corrected using standard vascular surgical techniques (e.g., CPT codes 36831, 36832, 36833). Angiography is adjunctively employed, when appropriate and medically necessary, to assess the functional integrity of afferent and efferent vessels remote from the surgical field.
- **Stents** - Subject to FDA approval of specific devices, stents are covered if used as a last resort to salvage a graft or fistula. Placement of an intravascular stent (e.g. CPT codes 37205-37206) and the associated supervision and interpretation (CPT code 75960) may be appropriate in selected clinical scenarios. The following clinical scenarios are examples where a stent may be considered for payment:
 - PTA induced rupture;
 - graft salvage (e.g., PTA is unsuccessful due to elastic recoil, stenosis has recurred is less than 3 months);
 - central veins stenosis or occlusion; and
 - aneurysm or pseudoaneurysm is present.

Stents used under experimental protocols are not covered unless used within the Category B Investigational Device Exemption (IDE) protocol.

Limitations:

When diagnostic non-invasive vascular studies are performed to evaluate an AV Shunt on a routine basis in the absence of signs and symptoms, the services are considered monitoring, and are not separately covered by Medicare.

In the absence of clinical findings suggesting the need to re-establish appropriate flow in a dialysis fistula, it is seldom reasonable and necessary to perform diagnostic angiography or sonographic confirmatory studies as part of the decision to treat (i.e., CPT codes 75710, 75820, 93990).

Services performed for percutaneous interventions to treat total occlusion of graft due to thrombus of more than one year in duration will be considered not reasonable and medically necessary.

The dispersing, maceration, and removal of thrombotic material are integral parts of percutaneous AV dialysis access declotting (CPT code 36870). These are not to be interpreted, or coded, as open thrombectomy or as thrombolytic infusion.

Intermittent boluses of anticoagulant or thrombolytic agents are integral to and included in the percutaneous thrombectomy of a dialysis access (CPT code 36870) and are not separately coded.

However, if a thrombus is present outside the graft and requires separately identifiable thrombolytic therapy, this portion of the procedure would be separately coded using CPT codes 37201 and 75896 plus the appropriate catheterization code(s). This therapy typically involves additional selection of the vessel involved, negotiation of an infusion catheter into the thrombus and prolonged infusion of drug to dissolve the clot. If thrombus has embolized into an artery or vein outside the AV dialysis access, it may be retrieved and removed mechanically to restore flow to the affected vessel. This would be coded as CPT code 37186 (list separately in addition to the code for primary procedure).

Angioplasty of vessels not documented to be stenosed significantly by angiography or ultrasound will be considered not medically necessary.

Dilation of the graft anastomotic site will be considered either arterial or venous, but not both.

The placement of stent(s) in a vessel(s) for which there has been no objective symptoms or limitation of function is considered to be preventive, and therefore not covered by Medicare.

Placement of a stent (CPT codes 37205-37206) and the associated radiological supervision and interpretation service (CPT code 75960) in an A-V shunt when there are no objective symptoms or limitation of function are considered preventative and therefore not covered.

Use of a device that is not FDA approved will be considered investigational and not medically necessary.

Claims will not be paid if documentation in the medical record (e.g., procedure report) does not verify that the services described by the submitted CPT codes were provided and/or were not medically necessary.

Medicare does not pay for services that are screening in nature or that are not providing clinically relevant information.

Other Comments:

For claims submitted to the fiscal intermediary or Part A MAC: This coverage determination also applies within states outside the primary geographic jurisdiction with facilities that have nominated National Government Services to process their claims.

Bill type codes only apply to providers who bill these services to the fiscal intermediary or Part A MAC. Bill type codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier or Part B MAC.

For dates of service prior to April 1, 2010, FQHC services should be reported with bill type 73X. For dates of service on or after April 1, 2010, bill type 77X should be used to report FQHC services.

Limitation of liability and refund requirements apply when denials are likely, whether based on medical necessity or other coverage reasons. The provider/supplier must notify the beneficiary in writing, prior to rendering the service, if the provider/supplier is aware that the test, item or procedure may not be covered by Medicare. The limitation of liability and refund requirements do not apply when the test, item or procedure is statutorily excluded, has no Medicare benefit category or is rendered for screening purposes.

For outpatient settings other than CORFs, references to “physicians” throughout this policy include non-physicians, such as nurse practitioners, clinical nurse specialists and physician assistants. Such non-physician practitioners, with certain exceptions, may certify, order and establish the plan of care as authorized by State law. (See Sections 1861[s][2] and 1862[a][14] of Title XVIII of the Social Security Act; 42 CFR, Sections 410.74, 410.75, 410.76 and 419.22; 58 FR 18543, April 7, 2000.)

Coding Information**Bill Type Codes:**

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

- 11x Hospital-inpatient (including Part A)
- 12x Hospital-inpatient or home health visits (Part B only)
- 13x Hospital-outpatient (HHA-A also) (under OPPTS 13X must be used for ASC claims submitted for OPPTS payment -- eff. 7/00)
- 18x Hospital-swing beds
- 21x SNF-inpatient, Part A
- 22x SNF-inpatient or home health visits (Part B only)
- 23x SNF-outpatient (HHA-A also)
- 28x SNF-swing beds
- 71x Clinic-rural health
- 72x Clinic-hospital based or independent renal dialysis facility
- 73x Clinic-independent provider based FQHC (eff 10/91)
- 77x Clinic-reserved for national assignment
- 85x Special facility or ASC surgery-rural primary care hospital (eff 10/94)

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the pol-

icy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

Revenue codes only apply to providers who bill these services to the fiscal intermediary or Part A MAC. Revenue codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier or Part B MAC.

Please note that not all revenue codes apply to every type of bill code. Providers are encouraged to refer to the FISS revenue code file for allowable bill types. Similarly, not all revenue codes apply to each CPT/HCPCS code. Providers are encouraged to refer to the FISS HCPCS file for allowable revenue codes.

All revenue codes billed on the inpatient claim for the dates of service in question may be subject to review.

0320 Radiology diagnostic-general classification
 0329 Radiology diagnostic-other
 0340 Nuclear medicine-general classification
 0341 Nuclear medicine-diagnostic
 0349 Nuclear medicine-other
 0359 CT scan-other CT scans
 0360 Operating room services-general classification
 0361 Operating room services-minor surgery
 0369 Operating room services-other operating room services
 0450 Emergency room-general classification
 0490 Ambulatory surgical care-general classification
 0520 Free-standing clinic-general classification
 0521 Clinic visit by member to RHC/FQHC
 0610 Magnetic resonance technology (MRT)-general classification
 0614 MRT/MRI-other
 0618 MRT/MRA-other
 0920 Other diagnostic services-general classification
 0921 Other diagnostic services-peripheral vascular lab
 0929 Other diagnostic services-other
 0960 Professional fees-general classification
 0981 Professional fees-emergency room
 0982 Professional fees-outpatient services
 0983 Professional fees-clinic

CPT/HCPCS Codes

Code	Description
35473	TRANSLUMINAL BALLOON ANGIOPLASTY, PERCUTANEOUS; ILIAC
35474	TRANSLUMINAL BALLOON ANGIOPLASTY, PERCUTANEOUS; FEMORAL-POPLITEAL
35475	TRANSLUMINAL BALLOON ANGIOPLASTY, PERCUTANEOUS; BRACHIOCEPHALIC TRUNK OR BRANCHES, EACH VESSEL
35476	TRANSLUMINAL BALLOON ANGIOPLASTY, PERCUTANEOUS; VENOUS
36005	INJECTION PROCEDURE FOR EXTREMITY VENOGRAPHY (INCLUDING INTRODUCTION OF NEEDLE OR INTRACATHETER)
36010	INTRODUCTION OF CATHETER, SUPERIOR OR INFERIOR VENA CAVA
36120	INTRODUCTION OF NEEDLE OR INTRACATHETER; RETROGRADE BRACHIAL ARTERY

Code	Description
36140	INTRODUCTION OF NEEDLE OR INTRACATHETER; EXTREMITY ARTERY
36147	INTRODUCTION OF NEEDLE AND/OR CATHETER, ARTERIOVENOUS SHUNT CREATED FOR DIALYSIS (GRAFT/FISTULA); INITIAL ACCESS WITH COMPLETE RADIOLOGICAL EVALUATION OF DIALYSIS ACCESS, INCLUDING FLUOROSCOPY, IMAGE DOCUMENTATION AND REPORT (INCLUDES ACCESS OF SHUNT, INJECTION[S] OF CONTRAST, AND ALL NECESSARY IMAGING FROM THE ARTERIAL ANASTOMOSIS AND ADJACENT ARTERY THROUGH ENTIRE VENOUS OUTFLOW INCLUDING THE INFERIOR OR SUPERIOR VENA CAVA)
36148	INTRODUCTION OF NEEDLE AND/OR CATHETER, ARTERIOVENOUS SHUNT CREATED FOR DIALYSIS (GRAFT/FISTULA); ADDITIONAL ACCESS FOR THERAPEUTIC INTERVENTION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
36215	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; EACH FIRST ORDER THORACIC OR BRACHIOCEPHALIC BRANCH, WITHIN A VASCULAR FAMILY
36216	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; INITIAL SECOND ORDER THORACIC OR BRACHIOCEPHALIC BRANCH, WITHIN A VASCULAR FAMILY
36217	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; INITIAL THIRD ORDER OR MORE SELECTIVE THORACIC OR BRACHIOCEPHALIC BRANCH, WITHIN A VASCULAR FAMILY
36218	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; ADDITIONAL SECOND ORDER, THIRD ORDER, AND BEYOND, THORACIC OR BRACHIOCEPHALIC BRANCH, WITHIN A VASCULAR FAMILY (LIST IN ADDITION TO CODE FOR INITIAL SECOND OR THIRD ORDER VESSEL AS APPROPRIATE)
36245	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; EACH FIRST ORDER ABDOMINAL, PELVIC, OR LOWER EXTREMITY ARTERY BRANCH, WITHIN A VASCULAR FAMILY
36246	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; INITIAL SECOND ORDER ABDOMINAL, PELVIC, OR LOWER EXTREMITY ARTERY BRANCH, WITHIN A VASCULAR FAMILY
36247	SELECTIVE CATHETER PLACEMENT, ARTERIAL SYSTEM; INITIAL THIRD ORDER OR MORE SELECTIVE ABDOMINAL, PELVIC, OR LOWER EXTREMITY ARTERY BRANCH, WITHIN A VASCULAR FAMILY
36593	DECLOTTING BY THROMBOLYTIC AGENT OF IMPLANTED VASCULAR ACCESS DEVICE OR CATHETER
36831	THROMBECTOMY, OPEN, ARTERIOVENOUS FISTULA WITHOUT REVISION, AUTOGENOUS OR NONAUTOGENOUS DIALYSIS GRAFT (SEPARATE PROCEDURE)
36832	REVISION, OPEN, ARTERIOVENOUS FISTULA; WITHOUT THROMBECTOMY, AUTOGENOUS OR NONAUTOGENOUS DIALYSIS GRAFT (SEPARATE PROCEDURE)
36833	REVISION, OPEN, ARTERIOVENOUS FISTULA; WITH THROMBECTOMY, AUTOGENOUS OR NONAUTOGENOUS DIALYSIS GRAFT (SEPARATE PROCEDURE)
36870	THROMBECTOMY, PERCUTANEOUS, ARTERIOVENOUS FISTULA, AUTOGENOUS OR NONAUTOGENOUS GRAFT (INCLUDES MECHANICAL THROMBUS EXTRACTION AND INTRA-GRAFT THROMBOLYSIS)
37186	SECONDARY PERCUTANEOUS TRANSLUMINAL THROMBECTOMY (EG, NONPRIMARY MECHANICAL, SNARE BASKET, SUCTION TECHNIQUE), NONCORONARY, ARTERIAL OR ARTERIAL BYPASS GRAFT, INCLUDING FLUOROSCOPIC GUIDANCE AND INTRAPROCEDURAL PHARMACOLOGICAL THROMBOLYTIC INJECTIONS, PROVIDED IN CONJUNCTION WITH ANOTHER PERCUTANEOUS INTERVENTION OTHER THAN PRIMARY MECHANICAL THROMBECTOMY (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
37201	TRANSCATHETER THERAPY, INFUSION FOR THROMBOLYSIS OTHER THAN CORONARY

Code	Description
37205	TRANSCATHETER PLACEMENT OF AN INTRAVASCULAR STENT(S) (EXCEPT CORONARY, CAROTID, AND VERTEBRAL VESSEL), PERCUTANEOUS; INITIAL VESSEL
37206	TRANSCATHETER PLACEMENT OF AN INTRAVASCULAR STENT(S) (EXCEPT CORONARY, CAROTID, AND VERTEBRAL VESSEL), PERCUTANEOUS; EACH ADDITIONAL VESSEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
75710	ANGIOGRAPHY, EXTREMITY, UNILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION
75791	ANGIOGRAPHY, ARTERIOVENOUS SHUNT (EG, DIALYSIS PATIENT FISTULA/GRAFT), COMPLETE EVALUATION OF DIALYSIS ACCESS, INCLUDING FLUOROSCOPY, IMAGE DOCUMENTATION AND REPORT (INCLUDES INJECTIONS OF CONTRAST AND ALL NECESSARY IMAGING FROM THE ARTERIAL ANASTOMOSIS AND ADJACENT ARTERY THROUGH ENTIRE VENOUS OUTFLOW INCLUDING THE INFERIOR OR SUPERIOR VENA CAVA), RADIOLOGICAL SUPERVISION AND INTERPRETATION
75820	VENOGRAPHY, EXTREMITY, UNILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION
75822	VENOGRAPHY, EXTREMITY, BILATERAL, RADIOLOGICAL SUPERVISION AND INTERPRETATION
75825	VENOGRAPHY, CAVAL, INFERIOR, WITH SERIALOGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION
75827	VENOGRAPHY, CAVAL, SUPERIOR, WITH SERIALOGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION
75896	TRANSCATHETER THERAPY, INFUSION, ANY METHOD (EG, THROMBOLYSIS OTHER THAN CORONARY), RADIOLOGICAL SUPERVISION AND INTERPRETATION
75960	TRANSCATHETER INTRODUCTION OF INTRAVASCULAR STENT(S) (EXCEPT CORONARY, CAROTID, AND VERTEBRAL VESSEL), PERCUTANEOUS AND/ OR OPEN, RADIOLOGICAL SUPERVISION AND INTERPRETATION, EACH VESSEL
75964	TRANSLUMINAL BALLOON ANGIOPLASTY, EACH ADDITIONAL PERIPHERAL ARTERY, RADIOLOGICAL SUPERVISION AND INTERPRETATION (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
75978	TRANSLUMINAL BALLOON ANGIOPLASTY, VENOUS (EG, SUBCLAVIAN STENOSIS), RADIOLOGICAL SUPERVISION AND INTERPRETATION
90940	HEMODIALYSIS ACCESS FLOW STUDY TO DETERMINE BLOOD FLOW IN GRAFTS AND ARTERIOVENOUS FISTULAE BY AN INDICATOR METHOD
93990	DUPLEX SCAN OF HEMODIALYSIS ACCESS (INCLUDING ARTERIAL INFLOW, BODY OF ACCESS AND VENOUS OUTFLOW)

ICD-9 Codes that Support Medical Necessity

It is the responsibility of the provider to code to the highest level specified in the ICD-9-CM (e.g., to the fourth or fifth digit). The correct use of an ICD-9-CM code listed below does not assure coverage of a service. The service must be reasonable and necessary in the specific case and must meet the criteria specified in this determination.

Code	Description
440.31	ATHEROSCLEROSIS OF AUTOLOGOUS VEIN BYPASS GRAFT OF THE EXTREMITIES
440.32	ATHEROSCLEROSIS OF NONAUTOLOGOUS BIOLOGICAL BYPASS GRAFT OF THE EXTREMITIES
442.0	ANEURYSM OF ARTERY OF UPPER EXTREMITY
442.3	ANEURYSM OF ARTERY OF LOWER EXTREMITY
444.21	ARTERIAL EMBOLISM AND THROMBOSIS OF UPPER EXTREMITY

Code	Description
444.22	ARTERIAL EMBOLISM AND THROMBOSIS OF LOWER EXTREMITY
447.1	STRICTURE OF ARTERY
451.82	PHLEBITIS AND THROMBOPHLEBOTIS OF SUPERFICIAL VEINS OF UPPER EXTREMITIES
453.81	ACUTE VENOUS EMBOLISM AND THROMBOSIS OF SUPERFICIAL VEINS OF UPPER EXTREMITY
459.2	COMPRESSION OF VEIN
729.81	SWELLING OF LIMB
996.1	MECHANICAL COMPLICATION OF OTHER VASCULAR DEVICE IMPLANT AND GRAFT
996.62	INFECTION AND INFLAMMATORY REACTION DUE TO OTHER VASCULAR DEVICE IMPLANT AND GRAFT
996.73*	OTHER COMPLICATIONS DUE TO RENAL DIALYSIS DEVICE IMPLANT AND GRAFT
* 996.73 (and not 585) is the code that describes ESRD with malfunctioning dialysis shunts.	

Diagnoses that Support Medical Necessity

Not applicable

ICD-9 Codes that DO NOT Support Medical Necessity

Not applicable

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation

Diagnoses that DO NOT Support Medical Necessity

Not applicable

General Information

Documentation Requirements

The patient's medical record must contain documentation that fully supports the medical necessity for services included within this LCD. (See "Indications and Limitations of Coverage.") This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures. Angiographic and ultrasound report studies may be required to document the need for angioplasty of arterial and venous vessels at the same setting.

Appendices

Not applicable

Utilization Guidelines

Services performed with excessive frequency will be denied as not medically necessary. Frequency is considered excessive when services are performed more frequently than generally accepted by peers and reasons for additional services are not justified by documentation.

Sources of Information and Basis for Decision

This bibliography presents those sources that were obtained during the development of this policy. National Government Services is not responsible for the continuing viability of Web site addresses listed below.

Hoggard J, Saad T, Schon D, Vesely M, Royer T. Guidelines for venous access in patients with chronic kidney disease. A position statement from the American Society of Diagnostic and Interventional Nephrology Clinical Practice Committee and the Association for Vascular Access. *Seminars in Dialysis*. 2008;21(2):186-191.

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Society of Interventional Radiology. Interventional radiology grand rounds. Topic: preservation of hemodialysis access 2004. <http://www.SIRweb.org>. Accessed 11/11/2009.

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Vessly TM, Beathard G, Ash S, Hoggard J, Schon, for the ASDIN Clinical Practice Committee. Classification of complications associated with hemodialysis vascular access procedures. A position statement from the American Society of Diagnostic and Interventional Nephrology. *Seminars in Dialysis.* 2007;20(4):359-364.

Advisory Committee Meeting Notes

Connecticut: 01/26/2010

Indiana: 01/25/2010

Kentucky: 01/28/2010

New York: 01/27/2010

This coverage determination does not reflect the sole opinion of the contractor or contractor Medical Director. Although the final decision rests with the contractor, this determination is developed in consultation with representatives from Advisory Committee members and/or from various state and local provider organizations.

Start Date of Comment Period

01/11/2010

End Date of Comment Period

02/24/2010

Start Date of Notice Period

Revision History Number

Not applicable

Revision History Explanation

Not applicable

Reason for Change**Last Reviewed On Date**

01/01/2010

Related Documents

This LCD has no Related Documents.

LCD Attachments

There are no attachments for this LCD

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LCD Comments

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All Versions

Updated on 12/30/2009 with effective dates 06/01/2010 - N/A

[Updated on 12/30/2009 with effective dates 06/01/2010 - N/A](#)

FROM ZHEALTH PUBLISHING

Featured Q&As

Q: How would I code a fistulogram if the catheter (after many sticks) was actually in the brachial artery instead of the fistula? The doctor dictates contrast refluxing into the graft and flow into the subclavian, axillary, innominate veins.

A: I would use codes 36120 and 75791. -Dr. Z

Q: The patient had a right common femoral puncture; abdominal aortogram was performed (36200/75625), then selective catheterization of the SMA with angiogram (36245/75726). Catheter could not be advanced into the celiac due to 90% stenosis seen on the SMA exam, which also revealed the celiac circulation supplied predominantly by collateral flow through the inferior pancreaticoduodenal

artery and gastroduodenal artery. Selective catheterization of the gastroduodenal artery/angio performed via the inferior pancreaticoduodenal artery collateral. What is the correct catheter placement and angiogram code for the gastroduodenal being approached from the SMA, or should it be celiac?

A: First of all, the 75625 for aortography should be deleted, as visceral angiography includes aortography in the CPT code description. That being said, it sounds like the approach was via the SMA to the inferior pancreaticoduodenal artery on to the gastroduodenal, which would make it a third order selective 36247 (36245 would be deleted), and the imaging code would be 75774 for additional imaging of an area initially viewed via the SMA injection. The "superi-

or" anterior and posterior divisions of the pancreaticoduodenal artery arise as a fourth order branch off the celiac artery (celiac to common hepatic to GDA to pancreaticoduodenal arteries), while the "inferior" anterior and posterior divisions of the pancreaticoduodenal artery arise off the SMA. -Dr. Z

Q: I really need some help with the E/M cases below:

1. We have within one group, two different specialist physicians. Can the cardiovascular/thoracic surgeon bill for post-op same day office visit care or subsequent hospital care when the interventionalist does the AAPRO, same diagnosis/problem, no complication mentioned? The interventional procedures, in these cases, have no global days attached.

2. Same situation as #1, only procedure IS global. I can understand the interventional radiologist would not bill, but what about the admitting physician, same group, again?
3. A med decision for an angiography (no global days) has been made by the cardiovascular surgeon in his office a day prior to the interventional radiologist performing the AAPRO. The next day the patient is admitted to the hospital for this procedure. Can the cardiovascular surgeon charge a new patient visit for the admit?

A: The preoperative and postoperative care of the patient is included in the procedure.

1. If the visit by the cardiovascular/thoracic surgeon is just as post-op for the angiogram (which is what this sounds like), then no, it cannot be reported separately, as it is part of the payment for the procedure. If the visit by the cardiovascular/thoracic surgeon is to discuss the plan of care based on the results of the angiogram (acting as a primary care physician), then it would separately reported. However, this doesn't sound like it was the case in your example.
2. Two physicians can split the surgical procedure and postoperative care when there is a global surgical period. Modifiers -54 and -55 are utilized, and there are specific guidelines that must be followed. Payment will be split between the physicians.
3. If the patient is just admitted for the angiogram and, as in

number 1 above, the cardiovascular surgeon is just performing the follow-up care after the angiogram, then no. If the visit by the cardiovascular surgeon is to discuss the plan of care based on the results of the angiogram (acting as a primary care physician), then it would separately reported. -Dr. Z

Q: After reviewing the new codes for 2010, could you please clarify the new codes for facet joint injections? Will we no longer need to code the S&I portion of the injection? The verbiage of the new codes indicates that the one new code will cover the procedure.

A: This is correct. Imaging guidance is included (bundled) in the new codes. This refers to CT and/or fluoroscopy for codes 64490-95 and ultrasound for codes 0213T-0218T. Do not bill separately for imaging guidance with these new facet/nerve injection codes. -Dr. Z

Q: If a patient was referred to my physician for a port-a-cath needle exchange, what code is assigned? The Huber needle was removed, and the port was cleansed with Chlorascrub in the usual sterile fashion. A 20 gauge 3 1/4 inch noncoring needle was placed under sterile technique. Blood return was good and flushed easily. The needle was packed with sterile gauze and covered with sterile Tegaderm. Would you consider this a 36576?

A: This is a nursing service and not a separately billable procedure in a physician office. -Dr. Z

Q: What if the doctor placed an

extension cuff prior to placing the AAA endograft so that he could place the endograft? Would you still be able to bill both the extension cuff and the AAA endograft itself?

A: If the extension cuff were placed within the normal landing zone of the AAA endograft primary device and docking limb, I would consider it just part of the procedure and not code separately. If the extension cuff were for the most part described as being beyond the distal end of the docking limb, then I would code for it separately. Great attention by the performing physician to clarify these issues is critical in a procedure such as this because the guidelines state that all angioplasty/stent placement within the stent graft deployment zone is bundled into the stent graft placement codes. -Dr. Z

Q: If CT fluoroscopy is used to place a g-tube, is the guidance included in code 49440?

A: Yes. -Dr. Z

Q: Is a PTA of the internal iliac/hypogastric artery a PTA of a visceral vessel or of a peripheral vessel?

A: As the common iliac and external iliac are coded as peripheral S&Is, and the surgical codes are 35473 for each common iliac, external iliac, and internal iliac, I would use code 75962 for the internal iliac (although I know it usually supplies the viscera of the pelvis, it can also provide collateral flow to the legs) to match code 35473. I think it would be a mismatch between codes 35473 and 75966 also. -Dr. Z

Q: I have two questions on two different patients. Please advise me when you get a chance. Thank you for your time.

1. Our EP lab states placing catheter in AV node and SA node correlates to the right atrium and HIS, so a complete EP study can be charged.
2. When they place a catheter in RVA and RVOT constitutes a complete EP study since they placed catheters in two out of three places.

A: 1) SA is the right atrium, AV node is the top of the bundle of HIS, so they are correct, as long as pacing and/or recording is done, and it is NOT for an AV node ablation, in which case the diagnostic study is bundled.

2) If RVA is right atrium, then yes, again, as long as recording and/or pacing is done and documented. Placing catheters does not constitute anything, just increases the likelihood that a study was performed. This also applies to the coronary sinus... placing a catheter there is not 93621; this code is for recording or pacing of the left atrium (which can be done via a catheter in the coronary sinus).
-Dr. Z

Q: We have recently started seeing reports like this:

The right kidney measures 10.6 x 4.2 x 4.3 cm in the longitudinal, AP, and transverse dimensions respectively. Isoechoic echotexture noted. No focal echogenic abnormality. No hydronephrosis or focal calculus. No perirenal fluid. The left kidney mea-

ures 9.9 x 4.3 x 4.1 cm in the longitudinal, AP, and transverse regions respectively. Homogeneous echotexture noted. No focal echogenic abnormality. No hydronephrosis or focal calculus. No perirenal fluid. No hydro-ureter. The pre void bladder measures 7.5 x 7 .0 by 7.3. Pre-void volume 205.9 cc. Post-void bladder measures 2.5 x 1.2 x 0.58. Post-void volume .9 cc.

In this case would you just code 76770? I guess we are a little confused about code 51798 because it says non-imaging. Would we only use code 51798 when they only mention the pre-void and post-void by itself and nothing else?

A: Code 51798 is a non-imaging study and is not reported for imaging of the bladder performed in conjunction with urinary tract ultrasonography. Here is what *CPT Assistant* December 2005 had to say about code 51798:

Code 76857, rather than 76770, should be utilized if the urinary bladder alone (ie, not including the kidneys) is imaged, whereas code 51798 should be utilized if a bladder volume or post-void residual measurement is obtained without imaging the bladder.

-Dr. Z

Q: What can the physician bill for the professional component of 3-D reconstruction of the aorta for surgical planning for vascular surgery if they are not paying for the technical component of the service? The Medicare payment for the existing code G0288 is in-

tended for the technical component only. Should the physician use code 76376-26 instead?

A: Code G0288 is for technical only. This isn't a diagnostic study, but is performed and used for surgical planning by another physician. There is no code or interpretation for or by the radiologist in this case. -Dr. Z

Q: If a radiologist does aspiration of three cysts in the left breast by ultrasound guidance, do you code 19000, 19001, 19001, 76942, 76942-59, 76942-59? I just want to make sure I understand this correctly.

A: We currently code based on the 15.3 NCCI Provider Policy Manual, which allows use of the guidance codes 76942, 77002, 77003, 77012, and 77021 only once per patient encounter, regardless of the number of lesions biopsied/aspirated, etc., at the same session. So, we currently recommend 19000, 19001, 19001, and 76942 as the correct codes. This is against all guidelines that we have had for the past fifteen years until this change occurred in the 14.3 Provider Policy Manual, so this is where confusion may arise. If there are any changes, we will be sure to post them on our website.
-Dr. Z

Q: Our interventional radiologist did a biopsy of the largest nodules in the left and right lobe of the thyroid gland (two separate stab incisions). Do we code 60100 twice with only one guidance code 76942? Thanks for your help.

A: Yes. That is our current recom-

mendation due to the directions from NCCI Provider Policy Manual 15.3. This has been out there for 15 months now with no changes or society comments, so we have no reason to not believe it. -Dr. Z

Q: With the new codes for AV grafts 36147 and 75791, how do you code if via one access into the graft and the farthest catheter placement is the SVC? Example: Declots where via only one ac-

cess into the graft; a fistulogram is performed, and declot of graft and SVC is performed. Code 36147 includes fistulogram and catheter into graft. Code 36010 includes catheter to SVC. Thanks in advance.

A: Via a single access, I would recommend using code 36147 only, despite the multiple locations of the catheter. We have been instructed that code 36147 includes

any subsequent catheter placement locations via the same access, so this describes your case where there has been one access but multiple catheter locations. Again, the use of this code may undergo a few reiterations as more information from the "creators" is released, so pay close attention to the literature for the latest information. -Dr. Z

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