Part B Insider (Multispecialty) Coding Alert

CODING UPDATES: It's Up To You To Resubmit Spine Surgery Claims

Carotid artery stenting no longer payable with 37216

Who says the **Centers for Medicare & Medicaid Services** never admits its mistakes?

In Transmittal 889 (Change Request 4399), CMS fixes some glitches in the 2006 physician **Fee Schedule** , and they're mostly retroactive to January. In the transmittal, CMS revises the following indicators:

• **Bilateral surgery indicators** for laminectomy add-on codes 63035, 63043 and 63044 and spinal anesthetic injection codes 64480 and 64484 change from "0" to "1". They were set at "0" by mistake. The carriers won't automatically correct any claims for these codes that you've submitted since January, so it's up to you to resubmit claims for those codes.

• **Multiple procedures indicators** for spinal graft codes 20931, 20937 and 20938 change from "2" to "0". Again, CMS is correcting a mistake. The carriers won't automatically correct claims, but you can resubmit them.

The change to the bilateral surgery indicators for spinal surgery codes is "a great relief," says **Rena Hall**, coder with **Kansas City Neurosurgery** in Missouri.

Carriers have been denying multiple claims for laminectomy add-on claims since January, and "unless you watch your denials closely, this is a lot of money," notes **Marcella Bucknam**, coding manager for the **University of Washington's** physician group in Seattle. It would be easy to miss a denial where you only received payment for one unit instead of two, especially with all the other codes you'd be billing at the same time.

Important: You won't get the money you're owed for these spinal surgery claims since January unless you resubmit them. It's a good idea to use a computer system that lets you research these claims easily, notes Hall.

Medical College of Wisconsin in Milwaukee will have 10 claims for laminectomy add-on codes and as many as 124 spinal graft code claims to research, according to coder **Sharon Hathaway**.

Watch Out For Embolic Protection In Descriptor

Current coverage changes include:

• Carriers won't pay for **carotid artery stenting** (CAS) along with embolic protection claims that include code 37216 (Transcatheter placement of intravascular stent(s) without distal embolic protection). There's a forthcoming transmittal that explains this non-coverage.

Explanation: This is pretty straightforward, because there are stent placement codes with descriptors that specifically say "with embolic protection." So you should just use those codes instead of 37216, which specifically says "without embolic protection," says Bucknam.

• Carriers also won't pay at all for **CPT code 43842** (Gastric restrictive procedure, without gastric bypass; for morbid obesity; vertical banded gastroplasty) on or after Feb. 21.

Medicare has never covered bariatric surgeries with a diagnosis of 278.01 (Morbid obesity), says **Patricia Williams**, a coder in the gastroenterology department at **Medical College of Ohio Physicians**. You can use morbid obesity as an

underlying cause when the patient has a medically necessary condition resulting from morbid obesity, she notes.

Finally, **CPT codes 11300-11313** now have a bilateral indicator of "9." And CMS introduced new codes G9041-G9044 for the low-vision rehabilitation demonstration project.