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Part B Insider (Multispecialty) Coding Alert

LOCAL COVERAGE DETERMINATIONS: You Can't Bill Temporary Pacemaker Or Anesthesia With Heart Catheterizations

Noridian expands stereotactic neurosurgery coverage

Several of the Part B carriers decided to start off 2006 with a bang--by introducing some groundbreaking new draft local coverage determinations (LCDs). Even if your own carrier doesn't yet have a policy on some new procedures, you can often glean a hint of things to come by looking at other carriers' draft policies.

Cardiology: Trailblazer Health Enterprises will cover left heart catheterization and coronary angiography, either separately or at the same time, in a number of different circumstances, including signs of coronary artery disease (CAD), acute heart attack secondary to CAD and signs of multi-vessel CAD after a heart attack, among others.

Example: A surgeon may be repairing a dysfunctional valve, assessing a transplanted heart for rejection, or considering correcting a congenital or acquired heart condition. Trailblazer won't pay separately for left heart catheterization with electrophysiologic or pacing studies--or endomyocardial biopsies.

Trailblazer will pay for aortic root aortography with known or suspected valvular disease, dysfunction of the prosthetic aortic valve, aortic aneurysm or dissection, a history of aortocoronary bypass, or anomalies and disease of the aortic arch.

Trailblazer also unveiled a list of circumstances it'll cover for right heart catheterization. These include valvular heart disease affecting the right heart, a number of diseases associated with right heart failure and cardiomyopathy, among others.

During catheterization, Trailblazer won't pay separately for insertion of a temporary transvenous pacemaker, an assistant at surgery, standby anesthesia or surgeon during angioplasty, the repositioning or removal of catheters, anesthesia or sedation during catheterization, or recording measurements such as EKG or intravascular pressures.

New Barrier To BBBD Coverage

Oncology: Noridian Administrative Services won't cover Blood Brain Barrier Disruption Chemotherapy (BBBD) at all. BBBD uses hyperosmolar agents to shrink the cells that form the barrier between the bloodstream and the brain, to allow more chemotherapy drugs to reach brain tumors. But Noridian worries this "aggressive approach" may be dangerous and increase the risk of seizures and strokes.

Neurosurgery: Noridian will cover stereotactic radiosurgery (CPT code 61793) only when the neurosurgeon is present and fully participating in a team, and when the treatment is medically necessary. The neurosurgeon can't bill for any of the 77000 codes, but the radiation oncologist can bill CPT code 77432 and other radiology codes to reflect the work he or she does.

Noridian will also cover multiple units of stereotactic body radiation therapy (SBRT), but the carrier won't cover more than five units per session. The carrier will cover either kind of stereotactic treatment for nervous system malignancies, tumors above the neck and benign brain tumors, among others.

The policy also lays out criteria for covering SBRT in other neoplasms, including spinal, lung, liver, kidney and pancreas. In general, patients must be good surgical candidates but unable to undergo surgery, and also unable to withstand other forms of radiotherapy.

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Internal medicine: Cigna Medicare will cover erythropoietin analogs, such as epoetin alfa and darbepoetin alfa, for a variety of conditions. These include anemia due to AZT treatment in AIDS patients, anemia secondary to chemotherapy, anemia of chronic kidney disease in patients not yet on dialysis, anemia as a result of malignancy, anemia caused by myelodysplastic syndromes (MDS), and anemic surgical patients at risk for transfusions during surgery.

Cigna won't cover epoetin or darbepoetin for patients with iron-deficiency anemia, patients who require "urgent correction of severe anemia," anemic patients with uncontrolled hypertension, anemic patients with "a known hypersensitivity to mammalian cell-derived products," and anemic patients with a known sensitivity to albumin. The treatment also won't be covered if the patient doesn't show significant improvement in hematocrit or hemoglobin levels or a significant decrease in transfusion requirements after three months.

In most cases, you have at least a month to comment online about these policies.

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