Part B Insider (Multispecialty) Coding Alert

More ASC Codes Are on the Way

If you were dissatisfied with the procedures that Medicare added to the covered list for ambulatory surgery centers, your time could
be coming.

The **Centers for Medicare & Medicaid Services** is working on the next proposed update to the ASC-covered codes, scheduled for 2005. The law requires CMS to update the list every two years, but CMS took much longer to put out the most recent update, which came out March 28.

But CMS officials told the July 25 physician Open Door Forum they hope to have a proposed rule for 2005 ASC updates published by the end of 2003, to allow lots of time to consider industry comments. CMS is looking at comments on the March rule, including ones that suggest newly created codes that CMS ought to cover in ASCs.

1. CMS will keep surveying your patients on their access to physician services, according to a notice in the July 28 Federal Register (Vol. 68, No. 144, pp. 44339-44340). CMS wants to find out if access problems exist, where and why they arise, whom they affect and what the consequences are.

2. Medicare will no longer demand a full month's worth of interest on overpayments that you repay within less than 30 days, according to a statement in the July 25 Federal Register (Vol. 68, No. 143, pp. 43995-43998).

3. CMS confirmed in another Register notice that it no longer covers multiple-seizure electroconvulsive therapy, electrodiagnostic sensory nerve conduction threshold testing, and noncontact normothermic wound therapy.

4. CMS revised its coverage manual for physician services furnished to dialysis inpatients. Thanks to a CPT Editorial change in the description for codes 90935 and 90937, CMS will now cover those codes for dialysis services furnished to acute dialysis patients requiring hemodialysis on an inpatient or outpatient basis.

5. Carriers shouldn't impose prepayment edits that result in automatic denial of services based solely on a diagnosis of a progressively debilitating disease, such as Alzheimer's, CMS says in Transmittal 46. For patients with Alzheimer's who have an illness or injury unrelated to their condition, physicians should code the other diagnosis as primary (e.g., **V43.64** for hip replacement, not 331.0 for Alzheimer's). Carriers can put into place edits only if a service is never reasonable and necessary for that diagnosis, such as EMG for Alzheimer's patients. But the carrier should still cover an EMG for "focal muscular weakness," even if that patient also has Alzheimer's, CMS insists.