Part B Insider (Multispecialty) Coding Alert

New Codes: Learn These New Codes For Biopsies, Venous Mapping

But telemedicine won't be expanded much at all

If your physician performs cutting-edge bone marrow biopsies or hemodialysis services, then you'll have a much easier time billing in 2005.

The **Centers for Medicare & Medicaid Services** is creating a new add-on G-code for a bone marrow aspiration performed with a bone marrow biopsy through the same incision on the same date of service. When a physician performs a bone marrow biopsy and then follows it up with a bone marrow aspiration, you would **CPT bill 38221** (Biopsy, needle or trocar) for the biopsy and also the new G-code for the aspiration. The new code will only be assigned 0.16 work RVUs.

Also, CMS is creating a new G-code for venous mapping for hemodialysis access placement. You'd use this code instead of 93971 (Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study) when the physician is about to create a hemodialysis access conduit using an autogenous graft. CMS says autogenous grafts have longer "patency rates," more durability and less risk of infection. You'd bill the new G-code with 36819, 36821, 36825, and 36832. You won't be able to bill the new G-code along with 93971 unless the services are performed on different parts of the body.

Longer patency rates mean the autogenous grafts stay open longer than other kinds, says **Larry Scher**, associate professor of surgery with **New York University School of Medicine** and attending vascular surgeon with **North Shore University Hospital** in Manhasset, NY. "They're doing the mapping to see if the veins are suitable to use for the operation rather than use an artificial conduit and have a worse long term outcome." He applauds the introduction of this new G-code.

Telemedicine On The Rise

Meanwhile, CMS rebuffed requests from the **American Telemedicine Association** and the **University of Kansas Medical Center** to add telemedicine payments for inpatient or emergency care. The requesters claimed that patients in rural areas might only have treatment from a primary care physician and might require more specialist diagnosis or care planning. But CMS said there wasn't enough data to justify adding those services.

Nor would CMS add speech and audiology services to the telehealth list, as the **American Speech-Language Hearing Association** asked. And also, CMS said it couldn't add medical team conferences and monthly physician supervision to the telehealth list, because there was no face-to-face patient visit for telehealth to replace.

But CMS agreed to add some, though not all, End Stage Renal Disease services to the telehealth covered list as the ATA asked. CMS said examining ESRD patients required a "hands on" examination, so it wouldn't cover a complete assessment as a telehealth service. But CMS would cover ESRD-related codes requiring two or three visits, or four or more visits, per month as telehealth services.

CMS is making strides toward using telemedicine more effectively, insists **Tom Brodmerkel**, executive vice president of **American Telecare** in Eden Prairie, MN. "Clinicians that are effective in the space right now recognize that [telemedicine] can be used correctly," he adds. Providers are bringing down the costs of telemedicine in rural settings and finding ways to be more effective over the phone, he adds.

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