Part B Insider (Multispecialty) Coding Alert

Newsbites: Carrier Considers Easing the Way for Overnight Pulse Oximetry Studies

Carriers clarify genetic testing, post-op epidural policies

If you're confused about how to bill for postoperative epidurals or pulse oximetry, then sometimes you have to look beyond your own carrier.

Many of the Part B carriers publish updates and lists of frequently asked questions on their Web sites every month. These can provide some helpful insights into tricky coding questions - or a heads up on what your own carrier may be instituting soon.

Here are some of the answers and clarifications that the carriers have published recently:

Medicare covers genetic testing (CPT Codes 83904 and 83898) for individuals with breast and/or colon cancer. Although Medicare has historically limited reimbursement to 40 sites of the body, Regence says it'll pay for up to 82 sites if it receives enough supporting documentation to prove that the testing was medically necessary.

One Virginia cardiologist asked Palmetto GBA about billing for pulse oximetry studies for oxygen saturation (94760 and 94761) when patients come into the office. Palmetto noted that the Medicare Physician Fee Schedule Database designates these codes as "Status T," meaning you can only bill for them if you're not being reimbursed for any other services under the Physician Fee Schedule.

But Regence says it's reconsidering its policy on overnight pulse oximetry for oxygen saturation. Now you can't bill for work-intensive overnight oximetry (CPT code 94762) separately because it requires supervision and isn't payable separately. But Regence is considering liberalizing its policy to make it easier for you to bill for 94762.

You can't bill for the work of filling out someone's death certificate, Regence says. Medicare only pays for the treatment of disease processes, and services after death aren't considered part of treatment. It's "inappropriate" to use a discharge or transfer code for someone who has died, Regence adds.

Cigna clarifies that you should no longer use an anesthesia code for postoperative pain management using an epidural if that epidural wasn't also used in the operation. Before 2003, you would have used 01996 (Daily hospital management of epidural or subarachnoid continuous drug administration) for all post-op pain management using epidural or subarachnoid continuous administration.

But CPT 2003 tells providers to bill for 01996 only when the epidural was placed for anesthesia and then retained for post-op pain management. If the epidural wasn't used for anesthesia but was added afterward, use an evaluation and management code instead. "Documentation should support the medical necessity and the level of the E/M code billed," Cigna adds.