Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Make the Most of April Updates to Angiography, Extracorporeal Circulation, and TED

All three changes are retroactive to January 1.

Medicare Physician Fee Schedule (MPFS) corrections are offering new payment opportunities this spring. But you'll need to do a little work if you want to take full advantage of the changes below.

1. Act to Capture 2013 Bilateral 36222-+36228 Payment

The April MPFS update corrects the bilateral indicator for cervicocerebral angiography codes 36222-+36228.

CPT® defines the codes as unilateral, which means each code is designed to represent the work required for a service on just one side of the body. But CMS's original bilateral indicator, 0, essentially resulted in bilateral services being paid at the same rate as unilateral services. The new indicator, 1, allows for bilateral services to be paid at 150 percent of the unilateral rate to compensate for the extra work required.

Effective date: The correction is retroactive to Jan. 1, 2013, so you should review your practice's 2013 claims to identify improperly paid bilateral services. Then, you should take steps to ensure you receive the additional bilateral reimbursement from your Medicare contractor. In the April update, CMS states that "Medicare contractors need not search their files to either retract payment for claims already paid or to retroactively pay claims. However, contractors shall adjust claims brought to their attention" (Transmittal 2663, CR 8169, www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2663CP.pdf).

Each MAC may have different appeal/claim correction processes, says **Laureen Jandroep, CPC, CPC-I, CMSCS, CHCI, CPPM,** of CodingCertification.org. Contact your MAC directly by its specific claim correction/appeal line, keeping in mind that MACs may have rules about the number of claims allowed per call or the types of corrections made by phone. But the MPFS change means MACs should be prepared to make this correction for claims.

Helpful: The change brings the CMS indicators in line with CPT® guidelines, which state, "When bilateral carotid and/or vertebral arterial catheterization and imaging is performed, add modifier 50 [Bilateral procedure] to codes 36222-36228 if the same procedure is performed on both sides. For example, bilateral extracranial carotid angiography with selective catheterization of each common carotid artery would be reported with 36222 and modifier 50."

Watch out: If the physician performs procedures on both the left and right sides but the services aren't identical, CPT® guidelines indicate you should use modifier 59 (Distinct procedural service) rather than modifier 50: "When different territory(ies) is studied in the same session on both sides of the body, modifiers may be required to report the imaging performed. Use modifier 59 to denote that different carotid and/or vertebral arteries are being studied." Also keep in mind that some payers may ask you to append modifiers RT (Right side) and LT (Left side) instead of using 50 or 59, so check for specific payer policies.

36221 note: The first code in the cervicocerebral angiography range is not included in the bilateral indicator change. The reason is that the code is defined as "unilateral or bilateral": 36221 (Non-selective catheter placement, thoracic aorta, with angiography of the extracranial carotid, vertebral, and/or intracranial vessels, unilateral or bilateral, and all

associated radiological supervision and interpretation, includes angiography of the cervicocerebral arch, when performed). The code without modifier 50 or RT/LT is appropriate for angiography either on one side or on two sides from nonselective catheter placement. CMS takes into account that the code may represent either a unilateral or bilateral service when developing relative value units (RVUs).

2. Change 33961 Global Period From ZZZ to XXX

Another April MPFS correction changes the global indicator for 33961 (Prolonged extracorporeal circulation for cardiopulmonary insufficiency; each subsequent day). The global indicator provides information about the global surgical period assigned to the specific code.

Prior to the April 1 change, the global indicator for 33961 was ZZZ, meaning "The code is related to another service and is always included in the global period of the other service." The new indicator is XXX, which means "The global concept does not apply to the code."

Key point: This change is also retroactive to Jan. 1, 2013.

Why the change? Indicator ZZZ typically applies to add-on codes that are only reported in addition to appropriate primary codes. Code 33961 was an add-on code until 2012 when it became a stand-alone code. Indicator XXX is more appropriate than ZZZ for 33961, which is reported once for "each subsequent day" of the service.

3. Get the Latest on G9157

A third change to the fee schedule alters the status code and PC/TC indicator for transesophageal Doppler (TED) code G9157 (Transesophageal Doppler use for cardiac monitoring).

Before the April 1 change, CMS listed the status B for G9157 in 2013, indicating payment for the code was bundled into payment for other services. The new status is A, meaning the code is active and paid under the physician fee schedule when covered. Medicare gives the code 2.99 RVUs, which equates to roughly $100.

CMS also will change the PC/TC status from 9, which means the professional/technical component concept doesn't apply, to the status 2, which means the code represents the professional component only. You shouldn't use modifier 26 (Professional component) or TC (Technical component) with a "2" code.

Effective date: These changes are retroactive to Jan. 1, 2013, meaning that if your provider performed the service on Jan. 1, 2013, or later, you should contact your MAC for proper payment of those services.

History: You may recall that CMS released and then rescinded Transmittal 2472, CR 7819, announcing G9157 would be added Oct. 1, 2012. The new code was related to the addition of "Monitoring of cardiac output (Esophageal Doppler) for ventilated patients in the ICU and operative patients with a need for intra-operative fluid optimization" as a covered service in the ultrasound national coverage determination (NCD manual section 220.5, www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/ncd103c1_Part4.pdf). Since the transmittal was rescinded, G9157 has been a source of confusion, so the April update will help clarify proper use of the code.