Part B Insider (Multispecialty) Coding Alert

Physician Notes: New Carotid Stent Technique Wins Medicare Coverage

But it must be part of an FDA-required study

If your practice is performing percutaneous transluminal angioplasty (PTA) with carotid stent placement, then you have reason to celebrate.

The **Centers for Medicare & Medicaid Services** has decided to cover PTA with stent placement, as long as it's consistent with the **Food and Drug Administration**-approved stent device. The use must be part of an FDA-required post-approval study. CMS says it'll consider the general question of whether Medicare should pay for all devices in FDA-required post-approval studies at a later date.

CMS says about 20 percent of cerebral infarctions stem from obstructive lesions in the carotid arteries, and these infarctions cause 80 percent of strokes. PTA with stent placement shows promise in treating symptomatic carotid artery stenosis.

To be covered patients must either have neurological symptoms and greater than 50 percent stenosis of the common or internal carotid artery by ultrasound or angiogram, or no neurological symptoms and greater than 80 percent stenosis. Also, patients must have a reference vessel diameter within the range of 4.0 mm and 9.0 mm at the target lesion.

CMS is revamping its process for developing HCPCS Codes to help payers reimburse new technologies more quickly. Working with its new Council on Technology and Innovation, CMS will expand existing public meetings to include all new requests for HCPCS codes for products, services and supplies. CMS also will add an appeals process and post preliminary public notices of coding decisions on its Web site. Further, CMS will streamline the application for new HCPCS codes to be more user-friendly, and ask for less marketing data. CMS plans to phase in the changes over an 18-month period starting in 2006.

Four issues that providers brought to the Physicians Regulatory Issues Taskforce will find some resolution in the Hospital Conditions of Participation, to be released soon. PRIT says on its Web site that the COPs will clarify whether an anesthesiologist who didn't administer a patient's anesthesia can perform a post-anesthesia recovery unit (PACU) evaluation and report. Also, the COPs will address the concerns of physicians who feel burdened by a requirement that the individual physician giving verbal orders must sign them. And the COPs will discuss whether podiatrists can perform "H&Ps on hospital inpatients," and the fact that Medicare requirements for the security of anesthesia carts currently exceed JCAHO requirements.

Separately, PRIT says the final physician fee schedule rule will clarify that you can use Q3001 to bill for radioisotopes used in brachytherapy, given that CPT is eliminating code 79900.