Part B Insider (Multispecialty) Coding Alert

Reader Question: Fight Back on 'Separate Dx' Demands

Question: One of our payers is taking back payment for 99291 and 99292, stating their reason is because we only billed one ICD9 code 434.91 (Cerebral artery occlusion unspecified with cerebral infarction). Where in the CPT® book can I find information to dispute this reasoning? The original bill included codes 99291, 99292, 31500 (Intubation, endotracheal, emergency procedure), and 93010-59 (Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only - Distinct procedural service).

Answer: The CPT® book actually says, on page 7 of the 2015 edition, a separate diagnosis for an E/M and a procedure on the same day is not required, "The physician or other health care professional may need to indicate that on the day a procedure or service identified by a CPT® code was performed, the patient's condition required a significant separately identifiable E/M service above and beyond other services provided or beyond the usual pre-service and post-service care associated with the procedure that was performed. The E/M service may be caused or prompted by the symptoms or condition for which the procedure and/or service was provided. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service. As such, different diagnoses are not required for reporting of the procedure and the E/M services on the same date".

Additionally, it is contrary to CPT® coding theory to require an additional diagnosis for 99292 since it is an extension of the time based 99291. That would be analogous to them developing a separate critical illness after 74 minutes of the first critical illness or injury. Appeal the denial with the CPT® reference appended.