Part B Insider (Multispecialty) Coding Alert

REIMBURSEMENT: Medicare Cuts Payment For Arterial Procedures

Beware bilateral changes this October

If your practice does a lot of selective catheter placement of the arterial system (36215-36216) your practice could be in for a major pay cut starting Oct. 3.

The **Centers for Medicare & Medicaid Services** changed the bilateral status indicator for 36215-36216 from "1" to "0," in Transmittal 652 (Change Request 4031), dated Aug. 19. Oftentimes, interventional radiologists will catheterize the right common carotid and the left internal carotid, and bill the same code twice, using the LT and RT modifiers, says **Jackie Miller** with **Coding Strategies** in Powder Springs, GA.

But once the bilateral indicator changes to "0" for these codes, you'll be unable to use either the LT/RT or 50 modifiers with them, says Miller. No matter how you bill for a bilateral selective catheterization, you'll only receive payment for one unit, she says. "I can't see the justification for not paying for two separate vascular families to be catheterized," Miller complains.

Miller cites language in the Medicare Claims Processing Manual (Chapter 12, p. 84) that says the "0" indicator prevents both the 50 and LT/RT modifiers.

The bilateral status indicators will also change for other arterial procedures starting in October: 35390 (Reoperation, carotid, thromboendarectomy, more than one month after original operation) and 61609-60612, for transection or ligation of the carotid artery.

The update to the physician fee schedule also changes the bilateral status indicator to "0" for coronary artery procedures 33508, 35500 and 35600; cardiovascular surgery codes 35681, 35685-35686, 36476 and 36479; ocular adnexa codes 67320-67340 and a host of spinal procedures.

Experts say that you may be able to use the 59 modifier with multiple instances of codes that don't allow bilateral modifiers - but only if you perform the procedure on separate body parts.

The fee schedule update also includes **Q9958** -Q9964, the new codes for high osmolar contrast material (HOCM), but only as non-covered codes.

Good news: But CMS said in the 2006 physician fee schedule proposed rule that Medicare will pay for Q9958-Q9964 starting in January. CMS will add RVUs to the HOCM codes by taking some RVUs away from exams that use contrast, so you may not see any additional reimbursement. But you could lose reimbursement if you forget to add the HOCM codes next year.