# Part B Insider (Multispecialty) Coding Alert

## YOUR PART B QUESTIONS ANSWERED: Consider All Aspects for Hypothyroidism Dx

Question: An established patient who recently had surgery and radiation therapy to treat her thyroid cancer reports to the doctor complaining of weakness, depression, and a lack of tolerance for cold weather. The physician performs a level-four E/M and diagnoses the patient with hypothyroidism caused by the recent treatments. Should I use 244.9 as an ICD-9 code for the hypothyroidism?

Answer: Your diagnosis coding should be more precise for this patient, as 244.9 (Unspecified hypothyroidism) does not reflect the postsurgical/postradiation state of the patient's condition.

When the patient has recently had thyroid surgery or radiation therapy that caused the hypothyroidism, choose the fourth digit based on the most recent factor influencing the hypothyroidism. If the patient most recently had surgery, report 244.0 (Postsurgical hypothyroidism). If the radiation therapy was more recent, report 244.1 (Other postablative hypothyroidism).

So let's say that the encounter notes indicate that the patient had radiation therapy more recently than thyroid surgery. On the claim, report the following:

• 99214 (Office or other outpatient visit for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a detailed history; a detailed examination; medical decision-making of moderate complexity) for the E/M;

• 244.1 linked to 99214 to indicate that the primary reason for the encounter is acquired hypothyroidism due to the radiation treatment that the patient had recently; and

• 193 (Malignant neoplasm of thyroid gland) linked to 99214 as a secondary diagnosis to represent the patient's thyroid cancer.

Get Pre-Authorization for Unlisted Procedures

Question: Our pain management specialist used pulse radiofrequency to treat a patient with suprascapular nerve pain. Since this procedure is new to our practice, is there anything we need to know before coding?

Answer: For pulse radiofrequency of any anatomic region, any nerve, you should use 64999 (Unlisted procedure, nervous system), according to CPT Assistant from August 2005. This is reinforced in the CPT book with the guideline: "For therapies that are not destructive of the target nerve, (eg pulsed radiofrequency), use 64999."

Be proactive: Billing for pulse radiofrequency is similar to billing for any other unlisted procedure. You might first try to obtain a preauthorization from the payer in a letter. If you have clinical trials that have been conducted by recognized bodies of physicians, make sure you include that information in your preauthorization letter requesting approval for a pain management procedure for which you will be using an unlisted code.

Pulse radiofrequency uses radio waves to intermittently affect the tissues around a painful nerve without nerve destruction. If your pain management specialist can explain why nerve destruction is not feasible and accurately document the patient's level of pain, it may help in obtaining pre-authorization.

Your letter also should include any current CPT codes that are similar in physician work, practice expense, and malpractice risk. Include in your letter a basic description of the procedure in layman's terms so that anybody who reads

it can understand.

Finally, ensure the payer understands the anticipated cost of the care with and without that procedure.If the procedure will might minimize the risk of future, more expensive procedures, most payers will look favorably on that fact.

Tune in to Video-Conference Cat. III Code

Question: Our doctor has agreed to be a specialty resource for a small rural hospital. She recently provided critical care services for an ER patient with acute seizures possibly due to viral encephalitis. But instead of being physically there at the hospital,our physician (a neurologist) was connected to the hospital via a remote real-time interactive video conference with the physician and ER patient. I know the codes for this E/M service are listed in the CPT Category III section, but they don't have RVUs assigned. How do I know what we'll get paid? Do I need to submit a suggested fee when I report Category III codes?

Answer: Although the Medicare physician's fee schedule does not assign relative value units (RVUs) to Category III codes, payers may still reimburse you for the codes -- but even if they don't, you must still report the Category III code.

Per the CPT section guidelines for Category III codes,"If a Category III code is available, this code must be reported instead of a Category I unlisted code. This is an activity that is critically important in the evaluation of healthcare delivery and the formation of public and private policy." Check with your individual payers about their Category III code reimbursement policies.

Providers often use the valid codes for other services (which may be Category I codes) as thebasis for their fees for these Category III codes since there are no RVU assigned. You should look for a basis code that has similar physician work, malpractice expense, and practice expenses.

For example, you and your neurologist may want to review the Category I critical care E/M codes (99291 and 99292, Critical care, evaluation and management of the critically ill or critically injured patient) for a comparison for these remote critical care services, which are reported with 0188T (Remote real-time interactive video-conferenced critical care, evaluation and management of the critically ill or critically injured patient; first 30 to 74 minutes) and +0189T (...; each additional 30 minutes [List separately in addition to code for primary service]).

Best bet: Explain this comparison in a cover letter to the payer, detailing what code(s) you based your fee on.

Capture Kegel Exercise Pay With E/M

Question: Is there a procedure code for billing for Kegel exercise teaching? Can we use code 90911 or possibly 97110?

Answer: There are no specific CPT or HCPCS codes for the performance of or teaching of Kegel exercises. To bill for teaching a patient how to properly perform these exercises, a nurse or medical technician must document a brief history and physical examination as well as the indications for and the expected goals of the Kegel exercises. Under these circumstances, you can then report 99211

(Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician ...) for this encounter.

About the service: Kegel exercises are voluntary contraction and relaxation of the perineal musculature including the urinary sphincter (pelvic diaphragm). These exercises are usually performed outside of the office without medical staff supervision, and are a non-invasive and non-surgical treatment for female and occasionally male stress urinary incontinence.

Pitfall: You should only use 90911 (Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry) for the teaching of biofeedback therapy with face-to-face supervision in office by a trained member of your medical staff.

Additionally, you should use 97110 (Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to

develop strength and endurance, range of motion and flexibility) only for pelvic floor muscle rehabilitation (PFMR) performed under one-onone supervision with a physician, physiotherapist, or ancillary office staff member specifically trained in an accredited physiotherapy program.