Codify
BY AAPC

Part B Insider (Multispecialty) Coding Alert

YOUR PART B QUESTIONS ANSWERED: Think Twice Before Reporting

Question: Is it appropriate to report both a CT and CTA of the same anatomic area performed on the same date?

Answer: Typically, charging for both CT and CTA exams of the same anatomic area on the same date is not appropriate. You should report the CTA alone.

CCI support: The Correct Coding Initiative (CCI) edits bundle many CT and CTA codes for the same anatomic areas. For example, CCI bundles CT codes 70450-70470 (Computed tomography, head or brain ...) into CTA code 70496 (Computed tomographic angiography, head, with contrast material[s], including noncontrast images, if performed, and image postprocessing). These edits have a modifier indicator of "1," which means you may override them by appending a modifier to the CT code when appropriate.

Rationale: Acquiring CTA data involves taking a few noncontrast images for calibration and identification followed by a full set of with-contrast CT data, according to the American College of Radiology (ACR) Radiology Coding Source (May-June 2003). CTA also involves reformatting the images (specifically 3D angiographic reconstruction post-processing), as well as interpreting the source images and the reconstructions.

Exception: Separately reportable same-day CTs and CTAs should be rare, but occasionally CT findings "will raise clinical questions that require performance of a CTA on the same day," the ACR article indicates.

For example, suppose a patient has a CT for severe abdominal pain. The radiologist finds a tumor in thehead of the pancreas, so the treating physician orders a CTA performed the same day "to evaluate the vascular invasion by the tumor." The radiologist performs and interprets a subsequent CTA, involving a new data acquisition. "In this scenario, although both procedures are performed during the same session or on the same day, the CT and CTA are separate and distinct procedures that use separate data sets and, therefore, are coded separately," the article states.

Experts warn: Before you code a CT and CTA for the same date, be sure both tests:

• Have an order from the treating physician

• Are medically necessary

• Are documented separately and completely.

Nurse Code Calls for Face-to-Face Encounter

Question: A doctor reviews lab test results and orders additional testing and medication changes for skilled nursing facility patients. Can the physician charge for this if the patient was not seen by the doctor or the nursing staff didn't see the patient face-to-face?

Answer: No. CPT code 99211 (Office or other outpatient visit for the E/M of an established patient, that may not require the presence of a physician; usually the presenting problem[s] are minimal; typically, 5 minutes are spent performing or supervising these services) requires direct contact between your office's incident-to employee and the patient.

In this case, no direct service occurred between the patient and the physician/nurse, particularly if the nurse discussed the reaction over the phone with the patient's caregiver.

Good news: Your doctor may not be giving away reviews/medical changes for free. E/M services include some related post-work time, so reviewing lab results might be included in the relatednursing facility visit (such as 99307-99310,

Subsequent nursing facility care per day, for the evaluation and management of a patient, ...) in which the doctor ordered the tests.

Don't Let Modifier 53 Stop Proper Coding

Question: A physician was performing a celiac plexus injection procedure but stopped halfway through due to an acute change in the patient's condition. Can I report the injection since it was not completed?

Answer: You would report 64530 (Injection, anesthetic agent: celiac plexus...) with modifier 53 (Discontinued procedure) appended. You use modifier 53 when a physician stops a procedure "due to extenuating circumstances or those that threaten the well-being of the patient," according to CPT.

Modifier 53 describes an unexpected problem, beyond the physician's or patient's control, that necessitates ending the procedure. The physician doesn't elect to discontinue the procedure so much as he is forced to do so because of the circumstances.

You might see the following scenarios as a cause to use modifier 53:

1. The patient develops a contraindication and the procedure must be discontinued for patient health reasons

2. The physician (provider) cannot continue the procedure for some reason

3. The equipment is not working properly and the procedure must be cancelled.

Procedures might stop at any time when the anesthesiologist or surgeon sees some risk that could threaten the patient's health if the case continues. If one of the above reasons does not apply, you should not use modifier 53.

Remember to also report the appropriate ICD-9 code, from the 996.XX-999.X code range (Complications peculiar to certain specified procedures), explaining to the payer the nature of the complication that necessitated terminating the surgical procedure.

Supplies Coding Depends On POS

Question: Can I use 99070 to report the use of supplies at our office?

Answer: The AMA and Medicare already factor essentials into a code's values on the physician fee schedule. If you're doing a procedure in the office that requires tools, surgical trays, or other supplies, the reasonable expectation is that you will be using equipment and that those costs have been accounted for in the price's procedure.

The site of service differential in the Medicare fee schedule, which pays more for a procedure when done in the office versus a facility, is meant to include these supplies and services.

For example, if the doctor does a biopsy in the office (such as 11100, Biopsy of skin, subcutaneous tissue and/or mucous membrane [including simple closure], unless otherwise listed; single lesion), he will use equipment to do it, and he may need to close the biopsy site with simple closure by suture or bandage. These supplies are considered bundled into the biopsy code and are not separately billable.

Exception: Private payers that do not follow the Medicare fee schedule might not include supply costs in their payments. In these cases, you could be paid for the item(s) by reporting 99070 (Supplies and materials [except spectacles], provided by the physician over and above those usually included with the office visit or other services rendered) for items that incur a cost in the office (POS 11). Check with the commercial payer to determine if this service is separately billable.