Outpatient Facility Coding Alert

CMS Coding Guidelines: Don't Panic When Coding 38220-59 if You Meet These Medicare-Approved Conditions

Remember your 'G' code as another option in some cases.

If your physician takes both a bone marrow biopsy and a bone marrow aspiration during the same encounter, whether you'll see Medicare reimbursement depends on the two guidelines below. But watch out: With OIG scrutiny and a HCPCS twist, these guidelines will put your coding savvy to the test.

Guideline 1: Append 59 for Different Sites and Encounters

A bone marrow biopsy and a bone marrow aspiration can provide different diagnostic information for certain leukemia evaluations and taking both specimens from the same patient on the same day isn't unusual, confirms **R.M. Stainton Jr., MD**, president of Doctor's Anatomic Pathology in Jonesboro, Ark.

Catch: Medicare and some other payers use the Correct Coding Initiative (CCI) edits to restrict how you bill for "sequenced" surgical procedures through the same incision. For biopsy and aspiration, CCI bundles codes 38220 (Bone marrow; aspiration only) and 38221 (... biopsy, needle, or trocar).

Bright side: You may report 38220 and 38221 together, according to the NCCI Policy Manual for Medicare Services, Chapter 5, Section E, if the physician performs the procedures at either of the following:

- Different patient encounters
- Different sites, meaning "in different bones or two separate skin incisions over the same bone" (e.g., contralateral iliac crests; iliac crest and sternum; different incisions in the same iliac crest)

For CMS and other payers that use the CCI edits, if these two procedures meet one of the above-listed criteria, you may override the edit by appending modifier 59 (Distinct procedural service) to 38220 and receive payment for both services, Stainton says.

Note that for 2015, CMS has defined new HCPCS modifiers to selectively identify subsets of Distinct Procedural Services (i.e., modifier 59). Next year, according to CMS Transmittal 1422, dated August 15, 2014, you will report one of the following modifiers instead of modifier 59:

- XE to indicate "Separate Encounter, A Service That Is Distinct Because It Occurred During A Separate Encounter"
- XS to indicate "Separate Structure, A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure."

Red flag: In one study, the Office of Inspector General (OIG) found that coders inappropriately used modifier 59 more often with 38220/38221 than any other code pair (http://oig.hhs.gov/oei/reports/oei-03-02-00771.pdf). Therefore, take extra care to append modifier 59 only when appropriate. If the procedures occur through the same incision, you should not use modifier 59 to report 38220 and 38221 together to Medicare.

Guideline 2: Code G0364 for Same Site

Medicare indicates you shouldn't use modifier 59 to bill 38220 and 38221 together for a bone marrow biopsy and aspiration through the same incision. But that doesn't mean you have no recourse.

Know the G code: For sequenced procedures, you'll report 38221 for the biopsy as usual. Then you can also report the aspiration to Medicare using G0364 (Bone marrow aspiration performed with bone marrow biopsy through the same incision on the same date of service), says Joyce Matola, billing manager for The Center for Cancer and Hematologic Disease in New Jersey. So be sure to let the physicians know that you need documentation on the number of incisions and the specific sites involved.

Commercial payer caution: Contact your payer for specific coverage guidelines before submitting your claim for bone marrow aspiration and biopsy. Some commercial and managed care payers may have guidelines that allow you to report 38220 and 38221 for sequenced procedures. Others may require you to report only the most extensive procedure.