APS Update

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New Chest Tube Codes for 2008

The American Medical Association made CPT changes for 2008 to the thoracentesis code set to provide a more consistent relationship between the subheadings and the codes that followed, allowing for enhanced ease of use of the manual.

The following codes have been deleted:

- ⇒ **32000** - Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent
- ⇒ **32002** - Thoracentesis with insertion of tube with or without water seal (e.g., for pneumothorax) (separate procedure)
- ⇒ **32005** - Chemical pleurodesis (e.g., for recurrent or persistent pneumothorax)
- ⇒ **32019** - Insertion of indwelling tunneled pleural catheter with cuff
- ⇒ **32020** - Tube thoracostomy with or without water seal (e.g., for abscess hemothorax, empyema) when performed (separate procedure)

They have been renumbered to the following codes:

- ⇒ **32421 -** Thoracentesis, puncture of pleural cavity for aspiration, initial or subsequent
  (Identical to code 32000)
- ⇒ **32422 -** Thoracentesis with insertion of tube, includes water seal (e.g., for pneumothorax) (separate procedure)
  (Nearly identical to code 32002; 32422 specifies the inclusion of a water seal)
- ⇒ **32560 -** Chemical pleurodesis (e.g., for recurrent or persistent pneumothorax)
  (Identical to code 32005)
- ⇒ **32550 -** Insertion of indwelling tunneled pleural catheter with cuff
  (Identical to code 32019)
- ⇒ **32551** - Tube thoracostomy, includes water seal (e.g., for abscess hemothorax, empyema) when performed (separate procedure)
  (Nearly identical to code 32020; 32551 specifies the inclusion of a water seal)

Congress and the Administration Working Overtime

As noted previously, the "fix" for physician payment under Medicare enacted in the waning days of 2007 will expire on July 1, 2008 at which point payment will drop by 10.1% across the board. As of this writing the Senate is working on a bill to match with a House bill passed last year to revise the physician payment system by dropping out the SGR (sustainable growth rate) formula which consistently calls for drastic reductions in physician payments with another system. The House version breaks physicians into six separate groups based on specialties, with growth targets for each group. Proponents of the revision say this permits a focusing of funding to promote better results. Skeptics note that this breaks a large lobbying group (the AMA) into splinter groups permitting easier passage of reductions in the future.

The Administration, not to be outdone, has reintroduced the potential to use the ICD-10 and has suggested that there be a trigger provision to reduce Medicare payments. The ICD-10 has been introduced before and is a radical revision of the diagnosis coding process which would require major reprogramming of virtually every clinical and financial information system package in the industry. The switch is targeted for implementation in 2011. The trigger provision calls for payment cuts to all provider types whenever less than 55% of the Medicare outlays are funded by the Medicare payroll taxes (meaning that the general fund revenues necessary to fund the program were higher than desired). The reductions would grow each year until the target was reached. Congress has been cool to the trigger provision but the use of ICD-10 outside the United States is now routine resulting in a higher likelihood that the ICD-10 will be required in the future.

Embolization and Occlusion

Transcatheter embolization is performed to achieve hemostasis at a particular site or as a treatment technique for unresectable tumors. It may also be used for palliative treatment of conditions such as hepatocellular carcinoma. There may be cases where more than one vessel is catheterized and embolized, but the CPT code for embolization is reported only once per operative field, regardless of how many vessels at that site are occluded. General industry standards define "operative field" as the "portion of an organ or body part that may be accessed via single operative exposure."

The CPT codes assigned for embolization are as follows:

- ⇒ **37204** - Transcatheter occlusion or embolization (e.g., for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, non-central nervous system, non-head or neck.
- ⇒ **61624** - Transcatheter permanent occlusion or embolization (e.g., for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord)
- ⇒ **61626** - non-central nervous system, head or neck (extracranial, brachiocephalic)

The CPT codes for RS&I are as follows:

- ⇒ **75894** - Transcatheter therapy, embolization, any method
- ⇒ **75898** - Angiography through existing catheter for follow-up study for transcatheter therapy, embolization or infusion

All diagnostic components of the procedure in determining where embolization should take place are separately coded. Follow-up angiography is also separately reported with CPT code 75898. The intent of this code is to report the angiogram at the conclusion of the procedure; angiograms performed during the embolization to verify progress of the procedure are included in the code and not separately billed.

Because procedures performed bilaterally entail two separate operative fields, two units of the appropriate CPT codes would be reported. For example, to report the right and left bronchial arteries codes 37204 and 75894 would each be reported twice. This can be accomplished by appending modifier 50 onto each code to indicate the procedure was performed bilaterally: 37204-50, 75894 -50.

Stark Changes Deferred, Anti-Markup Enacted

The Centers for Medicare & Medicaid Services (CMS) have initiated changes in the structure of payments for organizations which purchase diagnostic services. In essence, all technical and professional services provided through an "outside supplier" (a non-employee without a reassignment of benefits) have payment limited to the cost to the billing party.

In addition, the regulations alter the definition of "in office" to mean within the medical office space used by the group to furnish "substantially the full range of patient care services that the physician organization provides generally." Services provided outside that area, even though owned by the group, etc., are to be considered provided by an "outside provider" and payment limited to the net cost of the service which may not include overhead.

As can be seen, the effect of these items is to eliminate the ability of most physician practices, without appropriate excess office space, to take advantage of the in office ancillary exclusion. There are indications that CMS may revise some of these provisions to permit some more latitude for the practice to perform its own ancillary services, but there is no date indicated for such clarifications to be issued.

Medicare Fix Short Term

The pending 10% reduction in physician payments that was scheduled for January 1st, 2008 has been delayed until July 1, 2008 and replaced with a 0.5% increase. The prospects for an extension of that through the rest of 2008 and, indeed, the prospects of a more lasting reform of the physician payment system took a huge blow with the release of a CMS report indicating that total Medicare expenditures rose by 19% in 2006, largely as a result of the prescription drug benefit.

While the increase was not specifically related to physician payments, it creates an environment in which improvements in payment to any health care provider are highly unlikely. Incentive programs such as PQRI must be considered as other avenues to increase payment, as long as they exist. Even those programs must be considered as potential areas for savings (i.e. elimination of the program) under the Federal Government PAYGO approach.