

APS Update

RADIOLOGY NEWSLETTER

Volume 5

November 2008

Issue 11

Fluoroscopy Coding

There are many fluoroscopy CPT codes listed in the CPT book. For some procedure codes fluoroscopy is included and yet for others the procedure code is reported with the fluoroscopy as an additional code. But what do you do if fluoroscopy is provided in the operating room for a procedure and the radiologist is not present? The rule is the radiologist must be present and performing the imaging. In a July 2008 CPT Assistant, the AMA offered authoritative support for this rule. They stated "Because fluoroscopic imaging requires personal supervision, a fluoroscopic code should not be submitted if the physician is not present in the operating room [OR] during a procedure that uses fluoroscopy or fluoroscopic guidance." This also goes with the recommendation of the American College of Radiology.

On occasion there are times the radiologist will not be present and will only be reviewing the films taken in the OR during the fluoroscopic-guided procedure. If a hospital contact requires a formal interpretation, report the appropriate x-ray code based on the area that is evaluated. Per CPT Assistant, "Or if the physician who provides the study asks the radiologist for a formal report from permanent images, you also may report an x-ray code based on the radiologist's documentation."

APS Medical Billing
5700 Southwyck Blvd.
Toledo, OH 43614
419-866-1804 / 800-288-8325
www.apsmdbill.com

Medicare's Error Rate Testing Program

Recently, CMS has been issuing requests for documentation of services provided under the Comprehensive Error Rate Testing (CERT) program. The program is being pursued under the authority granted by HIPAA. The stated goal of the program is to determine if Medicare Part B carriers are paying claims correctly.

The requests are typically focused on a small sample of cases and encompass any records required to substantiate the billed CPT's. Based on our experience in other similar compliance oriented programs we have found:

1. "Errors" usually only means overpayment to the provider
2. Any sample based error rate may be extended to all similar services in a recoupment effort (it is noted that overpayments will be provided to the local Medicare contractor for recoupment).

Given recent efforts by Medicare under the RAC program to determine areas of potential recovery in combination with the CERT raises concerns over the use of the CERT findings. If you do receive a CERT request, comply with the request but closely monitor any actions related to those cases. Failure to comply with the request will result in a finding of overpayment.

(cont)

Moderate (Conscious) Sedation Coding

In 2006 CPT codes 99143-99145 and 99148-99150 were added to CPT. The subsections were expanded to describe 2 separate families of moderate sedation, each with unique guidelines, and differentiated by who is performing the service and the age of the patient. It is also a timed base code of 30 minutes, with an add-on code to report for each additional 15 minutes.

Moderate sedation does not include minimal sedation (anxiolysis), deep sedation or monitored anesthesia care (00100-10999). Per CPT, you can't report 99143-99150 with codes listed in CPT's Appendix G (or designated with a bull's-eye symbol) because those codes include moderate sedation. The following services are included in the codes and are not reported separately:

- ⇒ Assessment of the patient (not included in intra-service time)
- ⇒ Establishment of IV access and fluids to maintain patency, when performed
- ⇒ Administration of agent(s)
- ⇒ Maintenance of sedation
- ⇒ Monitoring of oxygen saturation, heart rate and blood pressure
- ⇒ Recovery (not included in intra-service time)

Intra-service time starts with the administration of the sedation agent(s), requires continuous face-to-face attendance, and ends at the conclusion of personal contact by the physician providing the sedation.

Codes for moderate sedation services provided by the same physician performing the diagnostic/therapeutic service that the sedation supports (99143 – 99145):

99143 Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; under 5 years of age, first 30 minutes intra-service time.

99144 Age 5 years or older, first 30 minutes intra-service time

+99145 Each additional 15 minutes intra-service time (List separately in addition to code for primary service) (Use this code in conjunction with 99143, 99144)

Codes for moderate sedation services provided by a physician other than the health care professional performing the procedure that the sedation supports (99148 – 99150):

99148 Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; under 5 years of age, first 30 minutes intra-service time

99149 Age 5 years or older, first 30 minutes intra-service time

+99150 Each additional 15 minutes intra-service time (List separately in addition to code for primary service) (Use this code in conjunction with 99148, 99149)

Medicare carriers in the past had only paid for 99148 -99150, but now a CMS Transmittal 1316 (Change Request 5618) allows carriers to pay for both types of sedation. The policy is as follows "If the physician performing the procedure also provides moderate sedation for the procedure, then payment may be made for the conscious sedation consistent with CPT guidelines."

ICD-10 Change Date Issued

The Department of Health and Human Services has announced a proposed date of October 1, 2011 to begin using the ICD-10 codes, X-12 (Version 5010) transaction standards, and the National Council for Prescription Drug Programs standards Version D.0.

The driver behind this effort is the growing obsolescence of the ICD-9 codes. Internationally, the ICD-10 is the standard which has caused a limited ability to compare disease related research between the U.S. and foreign studies. In addition, the ICD-10 has nearly 10 times the number of codes providing greater specificity in coding diseases. Finally, and perhaps most convincingly, ICD-9 is expected to start running out of codes next year.

The switch to ICD-10 will require expenditures from health care providers, insurance companies, etc. but the greatest impact is expected within the provider community.

(cont)