The Coding Institute

NEUROLOGY CODING ALERT

Your practical adviser for ethically optimizing coding, payment, and efficiency in neurology practices

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CCI 16.1 Update:

Identify Swapped Pairs to Ensure Correct EMG Modifier Placement

▶ ***Make sure you know when to put a modifier on +95920, starting now.***

Each time the Correct Coding Initiative (CCI) releases an update, new edits and deleted pairs get a lot of the attention. But if you ignore the swapped pairs in version 16.1, which took effect on April 1, you could be missing out on deserved reimbursement when your neurologist performs an electromyography (EMG) exam with intraoperative monitoring.

Version 16.1 is the second Correct Coding Initiative (CCI) update of the year. CCI 16.1 includes 2,054 new active pairs and 1,947 modifier changes, says **Frank D. Cohen, MPA, MBB,** senior analyst with MIT Solutions, Inc. in Clearwater, Fla.

"With each of the quarterly CCI updates, practices tend to primarily focus on the new CCI edits that they will have to deal with. They may not even consider that there's a potential swap in the columns, and the need to change which code should have the modifier appended," says **Marvel J. Hammer, RN, CPC, CCS-P, PCS, ACSPM, CHCO,** owner of MJH Consulting in Denver.

Keep reading and you'll come away with what you need to know about the top CCI 16.1 swapped pairs edits that will affect your neurology practice.

Flip the Modifier on GON and Ligament Blocks

One example of the importance of swapped pairs in CCI 16.1 occurs with greater occipital nerve (GON) injections. If your neurologist performs an injection on a patient's GON (64405, *Injection, anesthetic agent; greater occipital nerve*) and also performs a tendon injection in a separate anatomic location, such as the thumb for De Quervain's syndrome (20550, *Injection[s]; single tendon sheath, or ligament, aponeurosis [eg, plantar "fascia"]*), you'll need to know that the two codes have switched places.

Reasoning: The logic behind this kind of CCI edit is that the more extensive procedure is now in column 1.

The result: For example, 20550 is now the column 2 code, with 64405 in column 1. "It makes more sense, because you don't do greater occipital nerve injections as an anesthetic injection as a part of the tendon injection," Hammer says. This edit carries a "1" modifier indicator.

The same concept applies to other codes as well, including 62360 (*Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir*), 62361 (… *nonprogrammable pump*) and 62362 (… *programmable pump, including preparation of pump, with or without programming*) moving to the column 1 position and 62365 (*Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion)* which was swapped to the column 2 position. These swapped pairs carry the "0" modifier indicator.

Reminder: A modifier indicator of "0" means that you cannot unbundle or break the pair with any modifier. A modifier indicator of "1" means that you may be able to unbundle if medical necessity calls for it, and you have the proper documentation from your neurologist's notes.

EMG No Longer Gets the Modifier

Some EMG codes have also received important swapped pair updates in CCI 16.1. For example, if your neurologist performed a three-extremity EMG (95863, *Needle electromyography; 3 extremities with or without related paraspinal areas*), and then later that day performed intraoperative monitoring (IOM) when the patient went into surgery (+95920, *Intraoperative neurophysiology testing, per hour [List separately in addition to code for primary procedure]*), the way you'll report these codes has now changed.

Here's how: If your neurologist's documentation supports separately reporting 95863 and +95920 because he performed IOM in a separate and distinct session from the EMG diagnostic study, you now have to report modifier 59 (*Distinct procedural service*) with +95920, the new column 2 code.

Reasoning: Based on both the CPT manual and CMS coding manual instructions, CMS has exchanged which of these two procedures is considered the component of the other. +95920 is an add-on code, meaning it can never be reported as a stand-alone code. The code for the three-extremity EMG diagnostic study (95863) is not in the list of the acceptable primary or "parent" CPT procedure codes for the IOM add-on code.

Important: Even if you have all the right CPT and ICD-9 codes, if you put the modifier on the wrong code, your payer's system will likely deny it automatically. Be sure to double-check your modifier placement before sending the claim.

Check Out Infusion Changes Before Using Modifier 25

Although neurologists do not typically infuse chemotherapy, they can administer similar medications for treatment of conditions such as multiple sclerosis (MS), Hammer says. So you'll need to check out 16.1's swapped pair changes to codes such as 96413 (*Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug*).

Old way: In the past, if a patient underwent an infusion, you reported 96413. But if the patient had

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CONTACT INFORMATION

We would love to hear from you. Please send your comments, questions, tips, cases and suggestions for articles related to neurology coding and reimbursement to the Editor indicated below.

Mail: PO Box 50028, Provo, UT 84605-0028
Phone: (800) 508-2582 **Fax:** (801) 705-3942
Email: customerservice@supercoder.com

Editor: Joshua Thines (josht@inhealthcare.com)
Consulting Editor: Marvel J. Hammer, RN, CPC, CCS-P, ACS-PM, CHCO
Executive Editor: Leesa A. Israel, CPC, CUC, CMBS (leesai@inhealthcare.com)
President & CEO: Dan Fellars (danf@inhealthcare.com)
Content Director: Jennifer Godreau, CPC, CPEDC (jenniferg@inhealthcare.com)
Editorial Director: Mary Compton, PhD, CPC (maryc@inhealthcare.com)
Associate Publisher: Melanie Parker (melaniep@inhealthcare.com)
Marketing & Sales Director: Dave Sherwin (daves@inhealthcare.com)
Director of Operations: Kyle Widdison (kylew@inhealthcare.com)

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complications and was admitted to a hospital, you also reported the appropriate initial hospital care E/M code (99221-99223, *Initial hospital care, per day ...*) for your neurologist's E/M services. You would then append it with modifier 26 (*Professional component*) to bypass the applicable CCI edit.

New way: As of April 1, you will need to append modifier 59 to 96413, "if it's indeed separate and distinct," Hammer advises. The 16.1 CCI edits move 96413 into the column 2 position. The change was also made retroactive back to the original 4/1/2008 effective date.

This is extremely significant if you are working on denials for 96413 with an E/M service. You not only need to understand which code to append the modifier to, but also whether you need to use modifier 25 or modifier 59. ❑

Keep an Eye on Your Polysomnography Coding, Before OIG Does

▶ *Overusing Dx codes is just one way to attract an audit.*

The Office of the Inspector General (OIG) has had polysomnography sleep codes (95808-95811) on its watch list for a few years now. The popular sleep lab exam is also on the OIG's 2010 Workplan.

"Medicare reimbursement for polysomnography tests increased from $62 million in 2001 to $215 million in 2005," the OIG Workplan states.

Why it matters: The OIG wants to make sure practices are performing polysomnography properly, and for the right reasons. So if your neurologist interprets polysomnography tests or your sleep lab performs them, you'll want to pay attention now or risk a possible audit later.

OIG is Looking Hard at Apnea Diagnoses

The biggest reason the OIG is looking at polysomnography is that coders often misuse the diagnosis codes submitted to justify the test.

The scrutiny isn't unexpected, says **Jill M. Young, CPC-ED, CPC-IM**, president of Young Medical Consulting LLC in East Lansing, Mich. Medicare is seeing the rise in payments, "and they're starting to question the tests from a diagnosis perspective," Young says.

If you're unsure your diagnosis is up to snuff, there's at least one diagnosis you can rule out right away: chronic insomnia.

Medicare does not cover polysomnography (95808-95811, *Polysomnography; sleep staging ...*) for diagnosis of patients with chronic insomnia because it does not consider the test reasonable and necessary for that diagnosis. "Evidence at the present time is not convincing that polysomnography in a sleep disorder clinic for chronic insomnia provides definitive diagnostic data or that such information is useful in patient treatment or is associated with improved clinical outcome," CMS says.

There are many other conditions that Medicare does not cover, including:

- Cases where seizure disorders have been ruled out
- Patients with epilepsy who don't have specific complaints associated with a sleep disorder
- To evaluate a preoperative patient for laser-assisted uvulopalatopharyngoplasty without evidence of obstructive sleep apnea
- Depression-related insomnia
- For the diagnosis of circadian rhythm sleep disorders (jet lag, shift-work sleep disorder, delayed sleep phase syndrome, advanced sleep phase syndrome, etc).

Young also advises a second look at the appropriate ICD-9 codes in the 327 (*Organic sleep disorders*) code range, especially for 327.2x (*Organic sleep apnea*). "There is a very narrow window of diagnosis of sleep studies. Make sure your intake of information is as good as it can be," Young says.

(Continued on next page)

You Be the Coder

Decide If 96119 is Right for Neuropsych Test

Question: *We do neuropsych testing with computer-based testing. When the patient comes for the initial office visit, the neurologist orders the test, and we bill an E/M code for her office visit. When the patient comes back on a different day for the test, a nurse practitioner (NP) usually stays in the room with the patient. Our neurologist does the final interpretation. Since the test is computer-based, what code should we be reporting?*

Missouri Subscriber

Answer: See page 31. ❑

Reminder: If your neurologist documents daytime sleepiness, particularly with driving, morning headaches, and probable obstructive sleep apnea but the diagnostic test results don't confirm it, you can't code the sleep apnea. "If a test was negative, you would code the signs and symptoms," Young says.

Choose the Right CPT Code

A polysomnography test is not the same as a sleep study. Therefore, your coding isn't the same.

Note the differences: In a polysomnography evaluation, the patient's sleep is staged, meaning a setting is created to allow the patient to fall asleep. The exam occurs overnight, and a trained technician monitors the patient for the entire study. In contrast, sleep studies do not require the neurologist to stage the patient's sleep patterns during his interpretation of the diagnostic study data.

You'll use these codes to report polysomnography:

- 95808 — *Polysomnography; sleep staging with 1-3 additional parameters of sleep, attended by a technologist*
- 95810 — -... *sleep staging with 4 or more additional parameters of sleep, attended by a technologist*
- 95811 — -... *sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist.*

Pay Attention to Component Modifier

In order to properly report the correct components of the test and avoid denials or possible audits, you'll also need to understand how the exam works and how it might affect your modifier use.

Option 1: If your neurologist or sleep lab administers the study, owns all the equipment used (such as an 1-4 lead electroencephalogram [EEG]), employs the technician(s) and then interprets and reports the findings, you can simply report the component codes (95808-95811) without any modifier appended.

Option 2: If your neurologist only receives the test results, then analyzes, formulates an interpretation, and reports the findings, you would use the appropriate CPT code, then add modifier 26 (*Professional component*).

Option 3: When your lab, hospital, or center operates and owns or rents out the staging area and equipment, and employs the technicians, but sends the results to an independent neurologist, use modifier TC (*Technical component*) with the appropriate CPT code. ❑

Don't Get Tripped Up by Unusual Discharge Scenarios

▶ Report 99238 on date of service, even if patient doesn't leave that day.

Discharging a patient from a hospital is one of the most common scenarios you would code for your neurologist in a hospital setting. That doesn't mean you won't sometimes get tripped up by discharge anomalies.

Here are some common scenarios your neurologist could face when discharging a patient. Put these strategies to use and you're sure to bring the money in when the patient leaves.

Start With 99238 for Standard Discharge

If your neurologist finds the total discharge work to be relatively straightforward and doesn't require extended time, you'll report 99238 (*Hospital discharge management; 30 minutes or less*).

Example: Your neurologist admits an eight-year-old patient suffering from new onset of seizures. The initial inpatient hospital care E/M service occurs on Thursday. The neurologist stabilizes the patient's medication and discharges the patient to his parents five days later. Your neurologist notes that the total discharge work took 15 minutes. You would use 99221 (*Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components…*) for the initial hospital care work and 99238 for the discharge services.

If the discharge work takes longer than 30 minutes — perhaps because the patient is being transferred to another inpatient facility and requires extensive referral orders or to provide detailed instructions for continued home care to the relevant caregivers — you'll instead use 99239 (*… more than 30 minutes*). Your neurologist needs to document the total duration of time spent in performing the final discharge services.

Same Day Discharge = Different Code

For inpatient hospital care services your neurologist provides to a patient who is admitted and discharged on the same date of service, you should report the observation/ inpatient hospital care E/M codes: 99234-99236 (*Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date*).

Caution: "You can only bill one E/M code per day," says **Shelby Davidson, CPC, CMSCS**, coding educator with Ohio Health. "Billing two discharge codes on the same day would be inappropriate." Therefore, you should not report a separate discharge code when using 99234-99236.

The same rule applies when one neurologist performs the initial hospital care service, for example in the morning, and a neurologist of the same group performs the discharge services later in the same date of service.

Code Today for a Discharge Tomorrow

Discharge codes are time-based, not date-based, so if the patient doesn't leave the hospital on the same day your neurologist performs the discharge management services, your code choice won't change.

If the patient stays in the hospital "because the physician wanted to confirm a result before releasing, the physical discharge doesn't change the date for the services performed," says **Suzan Berman, CPC, CEMC, CEDC**, senior manager of coding and compliance in the departments of surgery and anesthesiology at the University of Pittsburgh Medical Center.

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Pointer: CMS doesn't specifically say that the physician must see the patient on the discharge date to bill a discharge code. Chapter 12 of the Medicare Claims Processing Manual states: "The E/M discharge day management visit shall be reported for the date of the actual visit by the physician or qualified nonphysician practitioner even if the patient is discharged from the facility on a different calendar date."

Example: Your neurologist sees an 85-year-old male who was admitted for post-traumatic seizures. He discharges the patient from the hospital on Friday but his family can't pick him up until Saturday morning. You would still report 99238 for Friday's date of service as that was the date your neurologist performed the face-to-face discharge services.

Not matching the discharge management services with the date the patient physically left the hospital may seem counterintuitive, but this is the CMS guideline, says **Julee Shiley, CPC, CCS-P, ACS-AN**, a coding professional in North Carolina. "As with other services, the date reported is the date performed," Shiley says. ❑

READER QUESTIONS

Tune in to Video-Conference Cat. III Code

Question: *Our neurologist 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 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?*

Ohio Subscriber

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

(Continued on next page)

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 the basis 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 – 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.

❏

Grab Dx Codes for Cohen's Syndrome Cases

Question: *We had a patient present recently that our physician diagnosed as Cohen's Syndrome. I'm not sure where to find information on this condition. What diagnosis codes should I use?*

Ohio Subscriber

Answer: You will need to look through your neurologist's documentation to pick up the patient's signs and symptoms of Cohen's Syndrome. Common characteristics include reduced muscle tone, also known as hypotonia (359.0, *Muscular dystrophies and other myopathies*), developmental delays (314.x, *Hyperkinetic syndrome of childhood*), intellectual disabilities (317, *Mild mental retardation* – 319, *Unspecified mental retardation*), small head size (742.1), and obesity (278.0x).

The 2010 ICD-9 Guidelines have a new directive regarding coding for syndromes: "Follow the Alphabetic Index guidance when coding syndromes. In the absence of index guidance, assign codes for the documented manifestations of the syndrome."

❏

Use Modifier 22 for Extra Repetitive-Stim Time

Question: *We've recently begun performing a test in our office that our neurologists are calling a "long exercise test." It's basically a repetitive stimulation test with multiple stimulations, and it takes over an hour to complete. I know that when we bill for it, we can only use the code once per nerve, but is there any way we can account for the extra time these tests take?*

California Subscriber

Answer: The test you're referring to does sound like a neuromuscular junction (NMJ) test, for which you would use 95937 (*Neuromuscular junction testing [repetitive stimulation, paired stimuli], each nerve, any one method*).

If your provider needed to spend a substantial amount of additional time performing the NMJ testing than typically required, you can look to append modifier 22 (*Increased procedural service)* to 95937. Your neurologist's documentation must support the substantial additional work and the reason for the additional work, such as increased intensity, time, technical difficulty of procedure, severity of patient's condition, or physical and mental effort required.

Neurologists will most often use NMJ as a diagnostic test for myasthenia gravis (358.0x). This test consists of recording muscle responses to a series of nerve stimuli (at variable rates), both before, and at various intervals after, exercise or transmission of high-frequency stimuli.

For your neurologist to perform the test properly, it will often require him to test two separate nerves. You could then report two units of service. If he tests a single nerve before and after exercise, however, you should report one unit of service per each nerve tested, not the number of times the nerve was tested or the number of stimulations per nerve.

❏

Gain Some Perspective on Alice in Wonderland Syndrome

Question: *A claim just crossed my desk with a diagnosis of Alice in Wonderland syndrome. Is this real? How do I code the condition?*

Virginia Subscriber

Answer: Although it sounds like the patient (or your provider) has been spending too much time at the movies, Alice in Wonderland syndrome (AIWS) is real. But while the ICD-9 manual does contain a code for Alice

in Wonderland Syndrome — 293.89 (*Other specified transient mental disorders due to conditions classified elsewhere; other*) — the manual also directs you to first code the associated physical or neurological conditions before the manifestation diagnosis code.

Coding this condition also offers a good lesson: Certain conditions have both an underlying cause and multiple body system manifestations, and sorting out the primary diagnosis can be tricky. For such conditions, the ICD-9-CM has a specific way you should report the codes. Wherever such a combination exists, you should find a "use additional code" note with the cause or origin code (also known as the etiology), and a "code first" note at the manifestation code. These instructional notes tell you the proper order of the codes — etiology followed by manifestation.

In the case of AWIS, you might use 346.0x (*Migraine with aura*), 345.4x (*Localization-related [focal][partial] epilepsy…*) for temporal lobe epilepsy, or 075 (*Infectious mononucleosis*).

The code descriptor indicates that it is a manifestation code. You can never list "in diseases classified elsewhere" codes as first listed or principal diagnosis codes. You must use them after an underlying condition code.

AWIS includes a number of symptoms, such as severe migraines with aura (the same kind Lewis Carroll, Alice's creator, is believed to have had), an altered body image (where the sizes of body parts such as head or hands are perceived incorrectly), and altered visual perception (where the sizes of external objects are perceived incorrectly).

Work From Diagnosis for Non-Neuro Conditions

Question: *At the request of an urologist, our neurologist consulted on an inpatient with altered mental status. The patient has urosepsis due to a urinary tract infection, an infection at the site of a ventriculoperitoneal (VP) shunt with suspected cellulitis, and a history of traumatic brain injury. Some of these conditions are out of the ordinary for us. How should I code them?*

Michigan Subscriber

Answer: The primary diagnosis is 780.97 (*Altered mental status*). Your secondary diagnosis will be 996.63 (*Infection and inflammatory reaction due to internal prosthetic device, implant and graft; due to nervous system device, implant and graft*). This code would not be linked as primary for your neurologist's inpatient visit as this is not the condition that is chiefly responsible for your physician's E/M services. However, it is a co-existing condition that affects the patient's care.

You'll also list V15.52 (*History of traumatic brain injury*) for the late effects of traumatic brain injury.

According to ICD-9 guidelines, "Either the term sepsis or SIRS must be documented to assign a code from subcategory 995.9 … The term urosepsis is a nonspecific term. If that is the only term documented then only code

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You Be the Coder

Decide If 96119 is Right for Neuropsych Test

(Question on page 27)

Answer: You'll need to choose between two codes: 96119 (*Neuropsychological testing [eg, Halstead-Reitan Neuropsychological Battery, Wechsler Memory Scales and Wisconsin Card Sorting Test], with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face*) or 96120 (*Neuropsychological testing [eg, Wisconsin Card Sorting Test], administered by a computer, with qualified health care professional interpretation and report*).

The difference between the neuropsychological testing codes is "who" administered the test.

Code 96120 "should be reserved for situations where the computerized testing is unassisted by a provider or a technician other than the installation of programs or tests and checking to ensure the patient is able to complete the tests. If greater levels of interaction are required, though the test may be computer administered, then the appropriate physician or psychologist (96118) or technician code (96119) should be used," according to a November 2006 *CPT Assistant* article.

The CPT code for the computer-based testing will be dependent upon the amount of interaction and/ assistance the individual patient requires. You would report 96120 if your NP is truly only monitoring to make sure the patient completes the test. If a specific patient requires more assistance or guidance, however, then you would report 96119 as the NP is functioning in a technician role rather than a monitoring role. Have your NP make a determination of her involvement for each patient as it may vary depending upon the patient's needs and capabilities. ❑

599.0 should be assigned based on the default for the term in the ICD-9-CM index, in addition to the code for the causal organism if known."

In your case, if the physician's documentation did not specifically include the term "sepsis or SIRS" or the causal organism, you would only report 599.0 (*Urinary tract infection, site not specified*).

❏

Diagnoses Matter for Tarlov Cyst Referral

Question: *Our neurologist saw a patient with a sacral Tarlov cyst. She is referring the patient to an interventional radiologist to have the cyst drained. I need the CPT and ICD-9 code to get this referral authorized. What should I use?*

Florida Subscriber

Answer: For the diagnosis code, the ICD-9 alphabetic index directs coders to review 355.9 (*Mononeuritis of unspecified site*). You may also want to review 349.2 (*Disorder of meninges, not elsewhere classified*) with your neurologist as it is reported for spinal meninges cysts.

The method used to drain the cyst is important for coding, but you would most likely use 62268 (*Percutaneous aspiration, spinal cord cyst or syrinx*) for authorization of the procedure.

Tarlov cysts are cerebrospinal fluid (CSF) filled sacs typically located at the S1, S2, and S3 level of the sacrum. These cysts (also known as meningeal or perineural cysts) can compress nerve roots, causing lower back pain (724.2), sciatica (724.3), urinary incontinence (788.30), headaches (784.0), constipation (564.00), sexual dysfunction (302.70), and numbness in the leg and/or foot (782.0). Tarlov cysts often are diagnosed using magnetic resonance imaging.

— *Clinical and coding expertise for* You Be the Coder *and* Reader Questions *provided by* ***Marvel J. Hammer, RN, CPC, CCS-P, ACS-PM, CHCO,*** *owner of MJH Consulting in Denver.* ❏

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Policy Director
American Association of Electrodiagnostic Medicine

Marianne Wink, RHIT, CPC, ACS-EM
University of Rochester Medical Center
Department of Neurology - Coding Manager