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CPT 2008 SPECIAL ISSUE

Medicare May Soon Cover FDG-PET Scans For Infection

▶ *CPT descriptor changes pave the way for coverage*

With all the bad news that's hit imaging lately, you're overdue for a break.

So it's good news that CPT 2008 greatly increases the number of patients for whom you can bill FDG Positron Electron Tomography (PET) codes 78811-78816. January's CPT update deletes the phrase "tumor imaging" from the descriptors for these codes.

That change opens the door for the **Centers for Medicare & Medicaid Services** (CMS) to start covering FDG-PET when your physician scans for infections and inflammations, as well as tumors.

"Just because the word tumor is removed doesn't mean CMS is going to change coverage," cautions **Denise Merlino**, president of **Merlino Healthcare Consulting Corp.** in Stoneham, MA. CPT 2008 removed the word "in anticipation of potential changes in coverage, or for private payors who might choose to cover other procedures," she notes.

Abass Alavi, a radiology professor at the **University of Pennsylvania**, wrote CMS in May to request an expansion in coverage for FDG-PET. Alavi originally requested coverage for all infection and inflammation, but after meeting with CMS' **Coverage and Analysis Group** (CAG), he narrowed the request to three conditions: chronic osteomyelitis, infection associated with hip arthroplasty, and "fever of unknown origin."

"FDG-PET's diagnostic efficacy is particularly well established" for these three conditions, he noted in his letter to CMS.

In response to his request, CMS opened a National Coverage Determination (NCD) review and will issue a decision early next year.

The **Society for Nuclear Medicine** (SNM), the **American College of Radiology** (ACR) and the **Academy of Molecular Imaging** (AMI) have all written to CMS to support covering FDG-PET for infection and inflammation, either as an alternative to conventional imaging, or when conventional imaging is "indeterminate."

In 2005, physicians performed roughly one million PET studies for tumors and approximately 100,000 non-PET nuclear medicine studies for inflammatory processes. When SNM and ACR requested the changes to 78811-78816, they predicted around 50,000 of those 100,000 yearly scans would involve PET instead.

Bottom line: You soon could have a new use for your PET scanner for thousands of patients. ■

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CPT 2008 SPECIAL ISSUE

Pay Attention To Cardiac MRI Documentation — Reap Rewards

▶ *Gain proper reimbursement for gastrostomy tube conversion next year*

It's official: The **American Medical Association** (AMA) has released the list of changes in CPT 2008. Here are some of the new codes you'll have to work with:

Cardiac MRI: CPT 2008 deletes cardiac Magnetic Resonance Imaging (MRI) codes 75552-75556 and replaces them with eight new codes.

Old way: Codes 75552-75556 divided cardiac MRI into three groups: MRI for morphology, for function (with or without morphology) and for velocity flow mapping.

New way: Codes 75557-75564 all cover cardiac MRI for both morphology and function. The first four codes cover cardiac MRI without contrast material and the second batch of four includes cardiac MRI "without contrast material, but followed by contrast material(s) and further sequences."

Each group of four further divides into plain cardiac MRI, cardiac MRI with flow/velocity quantification, cardiac MRI with stress imaging, and cardiac MRI with both flow/velocity quantification and stress imaging.

So you'll have to pay more attention to how your doctor documents cardiac MRI in 2008 to make sure you're coding for further sequences, stress imaging and other additional services, when applicable.

Gastrostomy tubes: You'll have nine new codes for insertion and other procedures involving gastrostomy and other tubes.

Old code: CPT 2008 deletes 43750 (*Percutaneous placement of gastrostomy tube, without imaging or endoscopic guidance*).

New codes: Three new codes cover insertion of gastrostomy (49440), duodenostomy or jejunostomy (49441), or cecostomy or other colonic (49442) tubes. The insertion is "under fluoroscopic guidance including contrast injection(s), image documentation and report." And CPT 2008 deletes 74350, which you currently use for fluoroscopic guidance for tube placement.

You'll use three other new codes when your physician replaces a gastrostomy or cecostomy (or other colonic) tube (49450), a duodenostomy or jejunostomy tube (49451), or a gastro-jejunostomy tube (49452).

Also: New code 49446 will come in handy when your physician converts a gastrostomy tube to a gastro-jejunostomy tube. Another new code (49460) covers the mechanical removal of obstructive material from a gastrostomy or any other type of tube. And finally, 49465 covers contrast injection(s) for radiological evaluation of an existing tube, including image documentation and report.

CPT 2008 also changes the wording of gastrostomy tube change code 43760. The new wording clarifies that the change of gastrostomy tube is percutaneous and "without imaging or endoscopic guidance." ■

CPT 2008 SPECIAL ISSUE

New Codes Will Ease Non-Chemo Infusion Coding

▶ *Your NPP's participation in long team conferences may lead to reimbursement*

Good news: If you've had trouble obtaining proper payment for subcutaneous infusion that's not for chemotherapy, then three new codes in 2008 could make your life much easier.

New codes 90769-90771 cover subcutaneous infusion for "therapy or prophylaxis." You must specify which substance or drug the physician provides. The codes cover infusion up to one hour, each additional hour, and "each additional pump set-up with establishment of new subcutaneous infusion site(s)."

Another code, 90776, covers each additional sequential IV push of a therapeutic, prophylactic or diagnostic injection which your physician provides in a facility. You'll use this as an add-on code with existing code 90774. The main difference between 90776 and existing code 90775 is that 90775 covers additional pushes of a new drug, while 90776 covers more pushes of the same drug.

As previously reported: You'll also have new codes for paravaginal repair via vaginal approach (57285) and laparoscopic approach (57423). You'll also have four new codes for laparoscopic hysterectomy (58570-57573). (See *The Insider*, Vol. 8, No. 31 for more on these codes.)

Also, *The Insider* previously reported you'll have new codes for smoking and tobacco cessation counseling (99406-99407), alcohol and/or substance abuse screening (99408-99409), telephone-based evaluation and management services (99441-99443) and online evaluation and management services (99444). (See *The Insider*, Vol. 8, No. 30 for more on these codes.)

Team conferences: CPT 2008 also includes three new codes for medical team conferences with an interdisciplinary team of health care professionals (93366-99368). These cover participation by a Non-Physician Practitioner (NPP) (99366), participation by a physician (99367), and participation by an NPP lasting 30 minutes or more (93368).

Say goodbye to "gastric band": CPT 2008 removes the phrase "adjustable gastric band" from the descriptors for 43770-43774 and 43848. Instead, these codes cover the more-inclusive (and correct) "adjustable gastric restrictive device."

Mesh becomes more versatile: The descriptor for mesh-placement code 49568 will now include language that clarifies you should report this code for the placement of mesh for debridement of necrotizing soft tissue infection. You'll use this code as an add-on when your physician performs an incisional or ventral hernia repair.

You'll still use 49568 for mesh placement for repair of ventral or incisional hernia. ■

Why — And When — You Should Stop Writing Off Modified Maze Procedures

When your surgeon performs the modified maze procedure at the same session as another surgery in 2007, you may have to write it off because existing codes 33254-33256 are only for stand-alone procedures.

But 2008 brings better options. In January, you'll have three new add-on codes (33257-33259) for when your surgeon performs the modified-maze along with a primary procedure. The three new codes break down into limited, extensive without cardiopulmonary bypass and extensive with cardiopulmonary bypass.

More new cardiovascular surgery codes:

- **When your doctor collects a blood specimen**, you'll have two new codes. CPT code 36591 covers collection from a completely implantable Venous Access Device (VAD), while 36592 covers collection from an established central or peripheral venous catheter, which is "not otherwise specified."
- **A cutting-edge aortic valve graft procedure**, known as the Tirone David Procedure or the Yacoub Procedure, gets its own code (33864). This involves an ascending aorta graft with a cardiopulmonary bypass for valve suspension. It also includes coronary reconstruction and "valve-sparing aortic annulus remodeling."

  Because the aortic valve is such a complex structure, no valve prosthesis can duplicate its function. So surgeons have developed procedures that either spare the aortic valve or replace it with "very similar autologous tissue," according to an Aug. 2006 article in the German journal *Herz*. ("Reconstructive surgery of the aortic valve: the Ross, David and Yacoub Procedures.")
- **When your physician places a wireless physiologic sensor** in the aneurismal sac during an endovascular repair, you'll have a new code (34806) to report this procedure. It includes radiological supervision and interpretation, instrument calibration, and collection of pressure data. There's also a new code for a bypass graft with vein, in the brachial-ulnar or brachial-radial region (35523).
- You can report **declotting by a thrombolytic agent**, or implanted vascular access device or catheter, using new code 36593. ■

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UROLOGY MYTHBUSTER

Ensure Your Robotic-Assist Coding Is Living Up to Its Potential

▶ *Key: Do payor-specific research before adding S2900 to another claim*

Myth: You can never get paid for robotic technology, such as the Da Vinci system, used with a prostatectomy and other procedures.

Reality: There's a new code to cover the robotic technology the doctor uses, S2900 (*Surgical techniques requiring the use of robotic surgical systems [list separately in addition to the code for primary procedure]*).

More and more physicians are using the Da Vinci system to aid with their prostatectomies. But obtaining the reimbursement your physician deserves will take some research — and some persistence.

Bad news: Medicare will never pay for S2900. S codes, found only in the HCPCS manual, are temporary national codes which Medicare never covers. But other payors, including some Medicaid programs, will cover S codes.

"It's a mixed bag" as to which payors recognize code S2900 and which ones don't, says **Christy Shanley,** billing manager for the **University of California, Irvine Dept. of Urology**. She's reported S2900 in addition to codes such as prostatectomy code 55866, nephrectomy code 50545, bilateral total pelvic lymphadnecotomy code 38571 and colpopexy code 57425. She's received payment for both codes by several HMOs on first submission, with no appeals necessary.

Some private payors who have paid on S2900 include **Aetna**, **United Healthcare**, **Blue Cross/ Blue Shield of Florida**, and **Keystone Healthcare** in Pennsylva-nia, says **Michael A. Ferragamo**, clinical assistant professor of urology at **State University of New York, Stony Brook**. You can expect payments ranging from $300 to over $1000 for S2900, he adds.

If your payor recognizes the S code, you should report the laparoscopic procedure code first and then S2900. You don't need a modifier because S2900 is an add-on code.

Be proactive: "For private non-Medicare carriers, when you're using robotic surgical technology, report S2900 to carriers and keep a record of which ones pay and which ones do not pay," Ferragamo suggests. Try appealing the first denials from a payor.

Tip: Avoid denials by finding out whether the payor wants S2900 or an unlisted code before your urologist performs the surgery. "When we request authorization for surgery we include this code too," Shanley says.

Bottom line: "As urologists increasingly use this technology, we'll see more payors recognizing this code and coders should call payor attention to this code," Ferragamo says. You should tell your carriers that "there are insurances that do pay for this, noting the increased skill and training the urologist needs to use the robotics," he adds. ■

Elbow Aside Those Unlisted Codes For Tennis Elbow Surgery

Fracture care will gain some new codes in 2008. For example, new codes 27267-27268 cover "*Closed treatment of femoral fracture, proximal end, head.*" The first code is for treatment without manipulation; the second covers treatment with manipulation. A third code, 27269, covers open treatment of a proximal-end femoral fracture, including internal fixation, if any.

Three similar new codes (27767-27769) cover closed and open treatment of posterior malleolus fracture. You already have codes covering treatment of medial malleolus fracture (27760-27766), but now you'll be able to code for posterior fractures as well.

Major change: Many other fracture care codes see changes in their descriptors. Previously, these codes included the phrase "with or without internal or external fixation." Now, instead they contain: "includes internal fixation, when performed." There's no longer any reference to external fixation.

You'll also have a new code (27416) for open osteochondral autograft of the knee (e.g., mosaicplasty) and one (28446) for "open osteochondral autograft, talus." Both autograft codes include the harvesting of autografts.

Another new code covers the repair of a fibula non-union and/or mal-union, with internal fixation (27726).

Three new codes cover tenotomy of the lateral or medial elbow for epicondylitis, tennis elbow or golfer's elbow. These codes cover percutaneous tenotomy (24357), open tenotomy (24358), and open tenotomy with tendon repair or reattachment (24359).

Four new codes cover surgical arthroscopy of the subtalar joint. They break down into surgery with removal of loose body or foreign body (29904), with synovectomy (29905), with debridement (29906), and with subtalar arthrodesis (29907). Another new code (29828) covers arthroscopy of the shoulder, in the biceps tenodesis region. ■

CPT 2008 SPECIAL ISSUE

Prepare To Code For Computer-Assisted Surgeries Next Year

▶ *Choosing an abdominal lesion excision code will get easier*

Cutting-edge surgeries and common procedures that your physician may already be performing will finally have new codes in 2008. They include:

• **Osteotomy of spine** (22206-22208). A parenthetical note mentions you'll use these new codes for "pedicle/vertebral body subtraction." Surgeons also refer to this procedure as "transpedicular three-column osteotomy." Until now, you've had no code to cover this procedure, which involves a posterior approach and includes three columns.

All three of these codes cover posterior or posterolateral approach of three columns and one vertebral segment. Code 22206 applies to the thoracic region, 22207 applies to the lumbar region, and 22208 is an add-on code for each additional vertebral segment.

• **Computer-assisted surgical navigational procedure** for musculoskeletal procedures (20985-20987). These codes break down into "imageless" computer assistance (20985), assistance with image guidance based on intraoperatively obtained images (20986) and assistance with image guidance based on preoperative images (20987). These are add-on codes, so you should list them in addition to the primary procedure.

• **Lung/pleura surgery** gets five new codes — but they're not really new. CPT 2008 deletes 32000-32005 and 32019-32020, and replaces them with new codes that have almost exactly the same descriptors.

The only difference between new thoracentesis codes 32421-32422 and 32000-32005 is that the descriptor of 32422 says "includes water seal ... when performed" instead of "with or without water seal." Similarly, 32551 is the same as 32020, except for the changed "water seal" language. New code 32560 is exactly the same as 32005, and 32550 is the same as 32019.

• **Open excision or destruction** of one or more intra-abdominal tumors, cysts or endometriomas (49203-49205). These codes replace 49200-49201, which included retroperitoneal as well as intra-abdominal objects.

Old way: Codes 49200-49201 merely divided into regular and "extensive" excision or destruction.

New way: Codes 49203-49205 provide you with an easier way to figure out which code to use. If the largest tumor is 5 cm or less in diameter, then you code 49203. If the largest tumor is between 5.1 cm and 10 cm in diameter, code 49204. If the largest of the tumors was bigger than 10.0 cm in diameter, code 49205.

• **Electronic analysis** of implanted gastric neurostimulator pulse generator (95980-95982). These codes include intraoperative analysis (95980), subsequent analysis without reprogramming (95981) and subsequent analysis with reprogramming (95982). There's also a new code for a non-invasive physiologic study of an implanted wireless pressure sensor in an aneurismal sac following endovascular repair (93982). ■

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Part B Coding Coach

Nail Down The 16-Minute Infusion Rule For Bulletproof Claims

▶ ***Here's why time matters on multi-substance infusion sessions***

When your physician performs an infusion involving multiple substances, you need to identify the type of infusion on the claim, or you could risk denials. You also need to know which infusion to list as primary, or the claim could get bounced right back to you.

Initial Codes Represent 'Main Reason' For Session

On multiple-substance infusion claims, you should report the initial infusion with 90765 (*Intravenous infusion, for therapy, prophylaxis, or diagnosis [specify substance or drug]; initial, up to 1 hour*) and +90766 (… *each additional hour [list separately in addition to code for primary procedure]*) — as long as the encounter meets these parameters, says **Sarah L. Goodman**, president and CEO of **SLG** in Raleigh, NC:

- The drug is being administered for therapeutic, prophylactic or diagnostic purposes.
- The infusion lasts at least 16 minutes.
- The infusion is not considered an inherent component of another procedure, such as a CT scan.
- A healthcare professional is continually present during the session.

The physician may report 90766 for "each additional hour" only if the infusion interval is greater than 30 minutes beyond the one-hour increment.

For example, if the patient receives an infusion of a single drug that lasts 1 hour and 45 minutes, the physician would report 90765 for up to one hour and 90766 for the additional 45 minutes.

<u>Don't be fooled:</u> "Initial infusion" does not automatically mean the first drug the physician administers because payors consider the initial infusion the "main reason" the patient is seeing the physician, says **Cindy Parman**, co-owner of **Coding Strategies Inc.** in Powder Springs, GA.

"The chronological order of the drugs, medications and/or substances infused is not important — what is critical is the primary reason for the patient to be there that day," Parman says.

Hierarchy Comes In Handy For Infusion Sessions

As a guide, Goodman uses this "unofficial hierarchy" of infusion services she culled from the APC Weekly Monitor. This list could come in handy when deciding how to code multiple infusion claims:

- chemotherapy infusions
- chemotherapy injections
- non-chemotherapy, therapeutic infusions
- non-chemotherapy, therapeutic injections
- hydration infusions.

Regardless of the order in which the physician administers the infusions, you should "report the 'initial' code for the service that falls highest on the list," Goodman says.

<u>Official guidelines:</u> "The initial code is the code that best describes the key or primary reason for the encounter, and should always be reported irrespective of the order in which the infusions or injections occur," according to Chapter 12, section 30.5E, of the Medicare Claims Processing Manual.

<u>Example:</u> The patient presents to the physician's office for chemotherapy treatment, and the physician first performs a therapeutic, non-chemotherapy infusion or injection (that is, antibiotics, steroidal agent, antiemetics, narcotics, etc.) followed by a chemotherapy infusion.

According to the hierarchy above, you should report the chemo as the initial infusion and the non-chemotherapy infusion or injection as the subsequent.

One Drug, And Then Another, Means Sequential Infusion

Once you have decided which is the initial infusion, you'll need to discover what type of secondary infusion(s) the physician administered. If the physician performs the secondary infusion(s) immediately after the initial infusion, she performed a sequential infusion, Goodman says.

When the physician provides sequential therapeutic infusions, report +90767 (… *additional sequential infusion, up to one hour [list separately in addition to code for primary procedure]*) for the service.

<u>Remember:</u> "A sequential therapeutic infusion code can only be reported when the initial drug or substance has finished infusing and a different therapeutic drug, medica-

Part B Coding Coach

tion or substance begins infusion," Parman says. Also, you have to have at least 16 minutes of infusion time to report 90767.

All Drugs at Once? Code Concurrent Infusion

There are multiple-substance infusion encounters during which the physician administers all of the drugs to the patient at the same time.

When this occurs, you should report the concurrent infusion code +90768 (*… concurrent infusion [list separately in addition to code for primary procedure]*) for the secondary substance.

You can report 90768 "when a therapeutic substance is infused in a separate bag at the same time as another therapeutic infusion, or at the same time as a chemotherapy infusion. This code reports the concurrent infusion of two therapeutic substances, or the concurrent infusion of a therapeutic substance and an antineoplastic substance," Parman says.

Remember: Use 90768 only once per encounter.

Leave Saline Admin Code Off Claim

One thing that you should never code for when reporting multiple-substance infusion is any fluid the physician uses to administer the IV drugs. Payors always bundle this service into the infusion codes.

"Fluid used as the vehicle for the delivery of other drugs or substances is not separately reported. This would include a 'flush bag' or KVO bag of fluid such as saline or D5W," Parman says.

(Note: See the article on page 259 for information on new non-chemotherapy infusion codes.) ■

Test Your 90765-90768 Coding Skills

▶ ***Determine where to focus your infusion coding education with this quiz***

You aren't alone if you find the ins and outs of infusion coding tough to tackle. Take this challenge to see whether you're an infusion coding master.

Question 1. True or False: The staff administers three drugs sequentially for therapy, prophylaxis, or diagnosis. You should always report the first drug administered as the initial infusion.

Question 2. How many times can you report +90768 (*Intravenous infusion, for therapy, prophylaxis, or diagnosis [specify substance or drug]; concurrent infusion*) per encounter?

Question 3. Should you separately report fluid used to administer drugs using hydration codes?

Answer 1. False. You should report 90765 (*Intravenous infusion, for therapy, prophylaxis, or diagnosis [specify substance or drug]; initial, up to 1 hour*) and, if you meet the time requirement, +90766 (*… each additional hour*) for the initial infusion that represents "the key or primary reason for the encounter, regardless of the order that the injections occur," says **Rhonda Buckholtz**, practice administrator at Wolf Creek Medical Associates in Oil City, PA.

Key: Staff may administer the drug that counts as the initial infusion in a second or third IV bag.

Remember to report each sequential drug administration with +90767 (*Intravenous infusion, for therapy, prophylaxis, or diagnosis [specify substance or drug]; additional sequential infusion, up to 1 hour*) if each meet the definition of infusion — at least 16 minutes of infusion time for each sequential drug.

Answer 2. One time. When staff members administer multiple therapeutic, diagnostic, or prophylactic infusions through the same IV line, you should assign 90768, Buckholtz says.

According to CPT's parenthetical note following 90768 in the manual, you should report 90768 only once per encounter.

Remember: CPT doesn't offer a code for concurrent chemotherapy, but you may use unlisted-procedure code 96549 (*Unlisted chemotherapy procedure*) for this situation when documented.

Answer 3. No. You shouldn't separately report fluid used to administer drugs. The CPT guidelines classify this as incidental hydration.

Example: Staff administers Phenergan and a 250-cc bag of common saline solution through an IV for a patient who had diarrhea and vomiting. The infusion lasts 30 minutes.

In this case, you should code only the drug infusion (90765) and the medication (J2250, *Injection, midazolam HCl, per 1 mg*) if you supplied the Phenergan, says **Patricia Davis**, business office supervisor at Middlesex Health System Primary Care in Middletown, CT. "Because the physician administers the drug through the same IV, coding both the hydration and the drug infusion would be double-dipping." ■

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PHYSICIAN NOTES

You Can't Change The Terms Of Relocation Bonuses After The Doctor's Already Relocated

▶ *AMA blitzes the airwaves to stop Medicare pay cuts*

Now that the **Centers for Medicare & Medicaid Services** finished laying out the sweeping changes it wants to make to the Stark self-referral law, it's ready to give some advice.

CMS issued an advisory opinion (CMS-AO-2007-01) on the Stark law in response to a question from a hospital and physician. Experts hope this may be the first of many opinions clarifying some thorny Stark issues.

The actual opinion is "pretty straightforward," says Washington, DC, attorney **Kevin McAnaney**, who was an official with the **HHS Office of Inspector General** for many years.

The hospital in question paid the physician a forgivable $25,000 loan and some monthly expenses and income guarantees to convince him to relocate to its geographic area. Circumstances changed, and the hospital and physician wanted to be able to change their agreement to ease the physician's financial constraints.

But CMS said that now that the doctor had already moved to the hospital's area, the hospital couldn't pay him any more, either directly or indirectly. "Whatever you put on the table has to be on the table before he comes" to the area, McAnaney says. "It's got to be an inducement for him to come. Once he's there, you can't change it."

The biggest lesson from the opinion is that you should build flexibility into your relocation agreements with hospitals in advance because you can't change them later, says McAnaney.

In other news:

• The **American Medical Association** (AMA) & **American Association of Retired Persons** (AARP) are buying television ads to put pressure on members of Congress to stop the 10-percent cut to your Medicare payments — before it's too late. Now's the time to write to your representatives and remind them that you might have to scale back your Medicare business if the cuts go through, the AMA urges.

• Maybe electronic medical records (EMRs) will start taking off now that **Microsoft Corp.** is offering a free personal health record on the Web. The project, known as HealthVault, includes cooperation from the **American Heart Association**, the **Mayo Clinic** and more, says the *New York Times*.

• As the Baby Boomers age, the doctor shortage will worsen. Already, seniors in some areas are having trouble scoring doctor's appointments, especially in primary care, according to *Prevention Magazine*. By 2020 Americans could be short as many as 200,000 MDs, according to a recent study, at www.aamc.org/workforce/recentworkforcestudies2007.pdf.

Primary-care physicians are already scarce; last year alone, demand for appointments rose by about 50 percent, *Prevention* claims. ■

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