**Blood draw via hep lock**

**Use 36592, except when part of another billable service**

A patient presents to the ED, and the physician orders a heparin (hep) lock, to keep open, and a laboratory test. The hep lock is placed first, and then staff members draw a blood specimen from it. Staff members may or may not use the hep lock during the balance of the visit. Is billing CPT code 36592 (collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified) for this blood draw via the hep lock correct? Does it matter whether the patient then has an IV treatment (either hydration or medication infusion)?

Reporting code 36592 for collection of a blood specimen drawn from a peripheral IV line or hep lock would be appropriate. You should report code 36592 when a drawing a blood specimen from any existing venous access except a completely implantable port.

However, the descriptor following 36592 in *CPT 2008 Professional Edition* states, “[D]o not report 36592 in conjunction with any other service.” Therefore, you should not report blood drawn from a central or peripheral catheter when part of another billable service. Because IV access is an inherent component of the infusion codes, the blood draw (36592) would be included in the infusion service performed and not separately reported. So if you reported any IV infusion or injection codes, reporting 36592 with those codes would not be appropriate. This issue has confused providers because 36592 is a CPT code listed under the category Central Venous Access Procedures, in which CPT states that to qualify for a code in the section, the tip of the catheter or device must terminate in the subclavian, brachiocephalic, or iliac veins, the superior vena cava, or the right atrium. The saline lock catheter described above does not seem to meet this requirement. However, CPT confirmed in June 2008 that 36592 was the appropriate code for this service.

**Cardiac catheterization: LIMA visualization**

**Use the same codes for native or bypass**

I’m still confused about the correct coding for left internal mammary artery (LIMA) and right internal mammary artery (RIMA) visualization. My questions concern the following CPT codes:

- 93539 (injection procedure during cardiac catheterization; for selective opacification of arterial conduits [e.g., internal mammary], whether native or used for bypass)

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LIMA

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➤ 93556 (pulmonary angiography, aortography, and/or selective coronary angiography, including venous bypass grafts and arterial conduits [whether native or used in bypass])
➤ 75756 (angiography, internal mammary, radiologic supervision and interpretation)

May we charge 93539 and 93556 for arterial (LIMA/RIMA) grafts that are postcoronary artery bypass graft (CABG) and use 93539 and 75756 for nongrafted arteries?

APC Answer Letter

βHCPro

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Use 93539 and 93556 for the arterial conduit, whether in its native state (pre-CABG) or used for bypass (post-CABG).

Fluoroscopy for temporary pacemaker

Be careful charging for the device

May we charge 71090 (insertion pacemaker, fluoroscopy and radiography, radiological supervision and interpretation) with 33210 (insertion of replacement of temporary transvenous single chamber cardiac electrode or pacemaker catheter [separate procedure])? I have a current charge for a temporary wire insertion and would like to add it, if possible.

Code and charge fluoroscopy for placement of the electrodes or generator, including the temporary pacemaker electrodes, to 71090. Ensure that the operative report includes appropriate documentation and confirm that the radiology department is not already billing for that code when the technician reports to the room to perform the service. Exercise caution when charging for the temporary pacemaker. It is bundled or included in many other procedures, including cardiac (e.g., electrophysiology procedures), noncardiac, and critical care. Medicare and many other insurance carriers do not pay for prophylactic temporary pacemaker placement during heart catheterization and coronary intervention procedures.

Modifier -59

Avoid pitfalls: Beware of conflicting information in physician reports

CPT code 71010 (radiologic examination, chest; single view, frontal) is a component of procedure 71020 (radiologic examination, chest; two views, frontal and lateral).
I understand that the first is part of the second. Is using modifier -59 (distinct procedural service) correct if reports are dictated for both exams?

The temptation to find a legitimate reason to assign modifier -59 to seek payment for all services provided to the patient seems to always exist.

This question addresses the legitimacy of assigning modifier -59 to two code sets, 71010 and 71020. Radiologic examination of the chest (i.e., a chest x-ray) facilitates the detection, diagnosis, staging, and management of pathophysiologic processes involving:

- Thoracic cardiovascular
- Pulmonary and mediastinal structures
- Contiguous coverings
- Bony thorax

Medicare Part B covers these examinations when medically necessary and appropriate for evaluation and management of a specific symptom, sign, disease, or injury. If you have a clinical question about such a report, clarify it with the physician.

However, note that many physicians may overuse modifier -59 in an effort to ensure that they receive payment for all services. Refer to the definition of modifier -59 in CPT 2009 Professional Edition, to evaluate the appropriateness of using modifier -59 to override an NCCI edit:

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non E&M services performed on the same day. Modifier 59 is used to identify procedure/services, other than E&M services, that are not normally reported together, but are appropriate under circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury not ordinarily encountered or performed on the same day by the same individual.

This description makes clear that assigning a modifier to CPT code 71010 representing a chest x-ray single view, frontal, on the same day as CPT code 71020 representing a chest x-ray two views, frontal and lateral, is not appropriate. The clinical scenario in this example does not meet the definition governing proper use of modifier -59. If the first exam occurred earlier in the visit, and the physician then ordered a repeat exam to confirm or deny specific findings, using modifier -59 would be appropriate. Its use for the same session is not appropriate.

NCCI article “Modifier -59” provides practical information on the proper use of modifier -59. It includes pitfalls to avoid when using modifier -59 to override NCCI edits. To read the article, visit www.cms.hhs.gov/NationalCorrectCodInitEd/Downloads/modifier59.pdf.

Outpatient surgery supplies

Who gets the bill? Does the facility bill at all?

A physician orders a DME-type item for an outpatient who underwent shoulder surgery. An “Ultra Sling AB” is a typical example. The hospital orders it from the DME supplier and provides it to the patient upon the physician’s request. The hospital then pays for the item but does not bill the patient’s account.

Why can’t the patient use the hospital’s temporary sling and obtain the Ultra Sling from the DME supplier en route home? Is it possible to have an arrangement with the DME supplier to provide the sling while the patient is hospitalized? If so, may the DME supplier bill the patient for the item directly?

In this situation, it’s unclear why the hospital is not charging for the sling. The hospital is certainly allowed to bill for the sling but will not receive any
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separate APC payment. If this is a Medicare patient, there will be no additional payment because CMS will consider this part of the outpatient surgery. The hospital could charge private payers and possibly receive payment for a percentage of charges submitted.

The hospital’s contracts with each of its individual payers are determinative.

Self-administered drugs

Bill insulin with revenue code 636 under certain conditions

Our MAC (WPS Health Insurance) considers insulin a self-administered drug. Does this mean that we may not bill for the injection when the patient is admitted for an outpatient encounter with diabetes (uncontrolled) or diabetic ketoacidosis (DKA)?

Insulin typically is self-administered and billed to Medicare with revenue code 637. However, insulin given subcutaneously to a patient with a diagnosis of uncontrolled diabetes, DKA, or diabetic coma is not considered self-administered.

You should bill it with revenue code 636. A patient who arrives at an outpatient facility with these diagnoses meets Interqual criteria for an inpatient admission, so you may bill the insulin with revenue code 636. The Medicare Benefit Policy Manual, Chapter 15, section 50.2 states:

Absent evidence to the contrary, presume that drugs delivered by subcutaneous injection are self-administered by the patient. However, contractors should examine the use of the particular drug and consider the following factors:

- **Acute Condition**—Is the condition for which the drug is used an acute condition? If so, it is less likely that a patient would self-administer the drug. If the condition were longer term, it would be more likely that the patient would self-administer the drug.

The Medicare Intermediary Manual, Transmittal 1790, CR 1115, section 3660.12, states:

**Self-Administered Drug Administered In An Emergency Situation.**—Pay for the ordinarily non-covered, self-administered drug insulin administered in an emergency situation to a patient in a diabetic coma. The provider bills for the aforementioned drug on Form HCFA-1450 or its electronic equivalent with bill type 13X, 83X, or 85X, as appropriate. The provider reports value code A4 and its related dollar amount [the amount included in covered charges for the ordinarily non-covered, self-administrable drug insulin administered to the patient in an emergency situation] in FLs 39–41 under revenue code 637 [self-administrable drugs not requiring detailed coding] in FL 42. The provider completes the remaining items in accordance with regular billing instructions.


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If it’s been more than six months since you purchased or renewed your subscription to APCAL, be sure to check your envelope for your renewal notice or call customer service at 800/650-6787.

Questions? Comments? Ideas?

Contact Managing Editor
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Hello everyone:

By now you've probably read Geri Spanek's letter in the December APC Answer Letter (APCAL) about the new changes.

As the new editor of APCAL, I thought I should introduce myself. My name is Bryn Evans and, like Geri, I'm a managing editor at HCPro. I joined the company earlier this year, and I already edit several other electronic and print newsletters, including Briefings on APCs, APC Weekly Monitor, APC Payment Insider, and Ambulatory Surgery Reimbursement Update. The APCAL process is a bit different, but not entirely foreign to me.

Geri has told me her biggest challenge editing APCAL stemmed from her limited coding knowledge, and she has assured me that because I am a credentialed coder with a certificate in coding (including anatomy and physiology studies), my learning curve won't be nearly as steep as hers was. She keeps telling me that this will also make life easier for my contributors. It will certainly help me follow and translate obscure points of coding. I hope I won't ever stop asking questions, and I hope you won't either.

APCAL is unlike our other newsletters in that it consists entirely of questions, answers, and a quiz, instead of traditional articles and sidebars. Geri and I have spent many hours reviewing and rereviewing all aspects of APCAL's production process.

I know Geri has told you that she remains at HCPro and has reassured me repeatedly that she will do everything possible to make the transition smooth for all of us.

Thank you for your continued interest in APCAL. I look forward to hearing from all of you, so please remember to e-mail me whenever you have a question or problem. Geri has said I can expect an engaged readership at APCAL. There's nothing I'd like better.

Best regards,

Bryn Evans, CPC-A
Managing Editor
bevans@hcpro.com
Quick coding quiz

Try your hand at this coding quiz based on this month’s APC Answer Letter

Questions

Question 1: Which modifier is appropriate for a distinct procedural service?
   a) -50    b) -59    c) -53    d) -57

Question 2: Which code should you use with caution when coding for a temporary or replacement pacemaker insertion?
   a) 71090    b) 33979    c) 33210    d) 76942

Question 3: Which code is appropriate with a pulmonary angiography, aortography, and/or selective coronary angiography, including venous bypass grafts and arterial conduits?
   a) 93532    b) 93556    c) 75756    d) 75676

Question 4: Which code is appropriate for pacemaker insertion, fluoroscopy and radiography, radiological supervision and interpretation?
   a) 71040    b) 71060    c) 71090    d) 71100

Question 5: Which code is appropriate for collection of a blood specimen using an established central or peripheral catheter, venous, not otherwise specified?
   a) 36589    b) 36590    c) 36591    d) 36592

Answers to the quiz can be found at the bottom of p. 5.
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