Coding and Billing

Coding of Adenosine

Adenosine is an injectable drug that has two (2) separate J codes. These separate J codes identify two (2) separate compounds that are administered and used differently. J0150 is used in a therapeutic manner and J0151 is used as a diagnostic agent.

- **J0150** – Injection, adenosine, 6 mg (not to be used to report any adenosine phosphate compounds; instead use A9270) **Use this code for Adenocard.**

- **J0151** – Injection, adenosine, 90 mg (not to be used to report any adenosine phosphate compounds; instead use A9270) **Use this code for Adenoscan.**

Adenocard (adenosine injection) can be used as a chemical shock agent to treat various forms of tachycardia by slowing conduction through the A-V node. When used in this manner, the 2002 HCPCS Level II Professional edition indicates that the correct code to use is J0150. One unit equals 6 mg; therefore if a 12 mg bolus dose is given, the units would be reported as (2).

Adenoscan (adenosine injection) is given as an intravenous infusion. It is a pharmacologic stress agent that produces maximal vasodilation of the coronary arteries, which is essential to myocardial perfusion imaging. It is used as an adjunct to thallium-201 during myocardial perfusion scintigraphy for patients who are unable to exercise at maximum levels during the stress test. When used as a stressor during diagnostic imaging, the correct code to use is J0151. For J0151, one unit is equal to 90 mg. Dosage is dependent upon the weight of the patient.

Please use these J codes according to their definitions for their designated use. Units should also be appropriate based on the code’s definition. If the J code is being used incorrectly based on the definition and units, the claim will be returned for correction.
Coding and Billing (cont.)

HCPCS Descriptions Changes

Effective April 1, 2002

A number of erroneous HCPCS descriptions in the 2002 Level II HCPCS books have been identified. The descriptions for the following drugs, biologicals and radiopharmaceuticals have been updated to reflect the appropriate dosage. Reimbursement has also been adjusted where necessary.

<table>
<thead>
<tr>
<th>Code</th>
<th>Name</th>
<th>2002 HCPCS Publication Dose</th>
<th>CORRECT DOSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A9504</td>
<td>Technetium TC 99m apcitide</td>
<td>None noted</td>
<td>Per Vial</td>
</tr>
<tr>
<td>A9508</td>
<td>Iobenguane sulfate I-131 per 0.5 mci</td>
<td>Per .5 microcurie (uCi)</td>
<td>Per .5 millicurie (mCi)</td>
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<tr>
<td>A9511</td>
<td>Technetium Tc 99m depreotide</td>
<td>Per microcurie (uCi)</td>
<td>Per millicurie (mCi)</td>
</tr>
<tr>
<td>A9605</td>
<td>Samarium sm 153 lexidronanim 50 mCi</td>
<td>Per MCI</td>
<td>Per 50 MCI</td>
</tr>
<tr>
<td>C1064</td>
<td>I-131 cap, each add mCi</td>
<td>Each additional microcurie (uCi)</td>
<td>Each additional millicurie (MCI)</td>
</tr>
<tr>
<td>C1065</td>
<td>I-131 sol, each add mCi</td>
<td>Each additional microcurie (uCi)</td>
<td>Each additional millicurie (MCI)</td>
</tr>
<tr>
<td>C1348</td>
<td>I-131 sol, per 1-6 mCi</td>
<td>I-131, per 1-6 mCi</td>
<td>I-131 sol, per 1-6 mCi</td>
</tr>
<tr>
<td>C9013</td>
<td>Co 57 cobaltous chloride</td>
<td>Per ML</td>
<td>Per 10 uCi</td>
</tr>
<tr>
<td>C9019</td>
<td>Caspofungin acetate, 5mg</td>
<td>50 mg</td>
<td>5 mg</td>
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<td>C9020</td>
<td>Sirolimus solution, 1 mg</td>
<td>Tablet, 1 mg</td>
<td>Solution, 1mg</td>
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<tr>
<td>Q2008</td>
<td>Fomepizole, 15 mg</td>
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</table>

Reimbursement

CT Scans

Effective on or after June 1, 2002

BCBSND will reimburse the professional component of a pelvic CT scan (codes 72191 – 72194) when billed with an abdominal CT scan (codes 74150 - 74175 and 75635). The technical component will continue to be reimbursed for both scans.

Imaging Agent for PET Scans

Update to Health Care News # 219

Correction is indicated in bold.

Effective for service dates on or after April 1, 2002, BCBSND will no longer make separate payments for the radiopharmaceutical or radiotracer when the following PET scans (Procedure codes 78459, 78491, 78492, 78608, 78609, 78810, G0030 – G0047, G0125, G0210-G0234 or S8085) are billed. All radiopharmaceuticals or radiotracers will be rejected as included in the scan code when billed with a PET scan. The reimbursement amounts for both the Hospital Outpatient Fee Schedule and Physician Payment Schedule will be adjusted to reflect the inclusion of the imaging agent.

Chemotherapy - Push Technique

Effective on or after April 1, 2002

BCBSND will reimburse for CPT code 96408 when billed with CPT code 96410 or CPT code 96412.

Also, CPT code 96420 will be reimbursed when billed with CPT code 96422 or CPT code 96423.

CPT Code

96408 - chemotherapy administration, intravenous push technique
96410 - chemotherapy administration, intravenous infusion technique, up to 1 hour
96412 - chemotherapy administration, intravenous infusion technique, 1 to 8 hours, each additional hour
96420 - chemotherapy administration, intra-arterial push technique
96422 - chemotherapy administration, intra-arterial infusion technique, up to 1 hour
96423 - chemotherapy administration, intra-arterial infusion technique, 1 to 8 hours, each additional hour
HealthCare News Issue #221

Ambulance

Coding and Billing

Update to HealthCare News #215

Effective April 1, 2002

Blue Cross Blue Shield of North Dakota (BCBSND) began accepting two new codes recently established by Medicare. The new codes are:

Q3019 – Ambulance service, Advanced Life Support (ALS), ALS vehicle used, Emergency transport, no ALS level service furnished

Q3020 – Ambulance service, ALS vehicle used, non-Emergency transport, no ALS level service furnished

Reminder: Codes A0426 and A0427 should not be billed if an ALS level of service is not provided.

To remain consistent with Medicare guidelines, BCBSND no longer recognizes Q3017 (Ambulance service, advanced life support (ALS) assessment, no other ALS services provided).

Routine supplies and equipment such as IV solutions, oxygen, tubing, masks, gloves, dressings, catheters, EKG supplies, back boards and glucose checks are included in the base rate.

Level of Service Criteria

Update to HealthCare News #216

The ambulance definitions in Health Care News # 216 have been adjusted to be consistent with Medicare’s revised definitions as published in the Federal Register final rule. The article should read as follows.

Effective January 1, 2002, BCBSND requires the use of the current ambulance HCPCS codes. Due to this change, there have been some questions regarding the criteria for the more intense levels of transport, specifically A0433 (Advanced life support, Level 2) and A0434 (Specialty Care Transport). BCBSND will use the same criteria as Medicare in defining the level of these services as listed in the February 27, 2002 Federal Register. All Level 2 ALS and Specialty Care Transports will be reviewed based on the following definitions:

A0433 - Advanced Life Support, Level 2 (ALS2) means either transportation by ground ambulance vehicle, medically necessary supplies and services, and the administration of at least three medications by intravenous push/bolus or by continuous infusion excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer’s Lactate); or transportation, medically necessary supplies and services, and the provision of at least one of the following ALS procedures: Manual defibrillation/cardioversion, Endotracheal intubation, Central venous line, Cardiac pacing, Chest decompression, Surgical airway, Intraosseous line.

A0434- Specialty Care Transport (SCT) means interfacility transportation of a critically injured or ill beneficiary by a ground ambulance vehicle, including medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic. SCT is necessary when a beneficiary’s condition requires ongoing care that must be furnished by one or more health professionals is an appropriate specialty area, for example, nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training.

Coding and Billing - Institutional

G0168 – Wound Closure by Adhesive

BCBSND has recently noticed on outpatient UB-92 claims, that G0168, wound closure by adhesive, is being used for the adhesive supply charge for items such as Dermabond®. G0168 should not be used to identify the supply itself – it is considered a procedure code and would be used in the situation when a wound or laceration repair was completed using this method of repair versus suturing. G0168 was established for the actual Dermabond® type (tissue adhesive) application, not as a supply code. G0168 is processed as a surgical procedure and the outpatient surgical roll-up applies. The following is an example of a corrected claim for G0168.

<table>
<thead>
<tr>
<th>Incorrect</th>
<th></th>
<th></th>
<th>Correct</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenue Code</td>
<td>Procedure Code</td>
<td>Units</td>
<td>Charge</td>
</tr>
<tr>
<td>251</td>
<td></td>
<td></td>
<td>$40.00</td>
</tr>
<tr>
<td>272</td>
<td>G0168</td>
<td>1</td>
<td>$65.00</td>
</tr>
<tr>
<td>450</td>
<td>G0168</td>
<td>1</td>
<td>$120.00</td>
</tr>
</tbody>
</table>

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
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<tr>
<td>Revenue Code</td>
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<td>Units</td>
<td>Charge</td>
</tr>
<tr>
<td>251</td>
<td></td>
<td>2</td>
<td>$40.00</td>
</tr>
<tr>
<td>272</td>
<td>NO HCPCS</td>
<td>1</td>
<td>$65.00</td>
</tr>
<tr>
<td>450</td>
<td>G0168</td>
<td>1</td>
<td>$120.00</td>
</tr>
</tbody>
</table>
Assistant at Surgery

Effective January 1, 2002, the following CPT codes were added to the Assistant at Surgery list.

CPT Codes

34800 – Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using aorto-aortic tube prosthesis

34802 - Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using modular bifurcated prosthesis (one docking limb)

34804 - Endovascular repair of infrarenal abdominal aortic aneurysm or dissection; using unibody bifurcated prosthesis

34808 – Endovascular placement of iliac artery occlusion device

34812 – Open femoral artery exposure for delivery of aortic endovascular prosthesis, by groin incision, unilateral

34813 – Placement of femoral-femoral prosthetic graft during endovascular aortic aneurysm repair

34820 – Open iliac artery exposure for delivery of endovascular prosthesis or iliac occlusion during endovascular therapy, by abdominal or retroperitoneal incision, unilateral

34825 – Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic aneurysm; initial vessel

34826 – Placement of proximal or distal extension prosthesis for endovascular repair of infrarenal abdominal aortic aneurysm; each additional vessel

Acute Rehab Admission Criteria

Effective March 1, 2002

BCBSND members admitted to a participating facility in the state of ND will be evaluated according to admission criteria listed below prior to transfer to Acute Rehab.

To ensure appropriate and cost-effective transfer of members to Acute Rehab, onsite nurses will evaluate all requests for Acute Rehab transfers according to admission criteria. In the event an onsite nurse is unavailable, Case Management will review and make a determination. The telephone number to call for Case Management is (800)336-2488 or 277-2100.

All of the following must be met:

• Length of Stay (LOS) has exceeded the average length of stay (based on DRG grouper for age and diagnosis);

• Anticipated LOS is at least 5-10 days;

• Member is capable of actively participating in therapy for a minimum of 3 hours per day;

• Multi-disciplinary therapies are available;

• Member has not met his/her maximal potential;

• Therapy services have been initiated at the acute level of care;

• Member is not appropriate for a lower level of care or outpatient services;

• Provider is licensed as Acute Care Rehab and JCAHO accredited.

DVAC Coding Guidelines

DRG Validation Advisory Committee

The DVAC members have worked hard over the past year to create the following coding guidelines. These guidelines are for coding assistance only and are not to be used in determinations for appropriate level of care. They are not meant to replace the official coding guidelines contained in Coding Clinic but are to be used as a tool for determining if documentation supports coding a condition. The use of physician queries is suggested to clarify ambiguous documentation. Please refer to pages 5 through 8 for coding guidelines.
DVAC Coding Guideline:  
Postoperative Nausea and Vomiting

It is not unusual for a patient to experience some nausea and vomiting following surgery. All patients require care and observation following surgery. When the patient has experienced these symptoms for longer than 24 hours and the significance of the symptoms requires more than routine care or extends the length of stay, the coding of postoperative nausea and vomiting may be appropriate. The physician's documentation should link the diagnosis to the procedure before a complication code is assigned. The physician's documentation should demonstrate that the nausea and vomiting was more than anticipated in the post surgical period.

Signs and Symptoms

- Persistent nausea and vomiting (2-3 days postoperative)
  - Documented at least twice within physician and nursing notes
- Signs of dehydration
  - Elevated BUN
  - Orthostatic blood pressure
  - Lightheaded/dizzy
  - Elevated heart rate
  - Abnormal electrolytes
  - Poor skin turgor
  - Dry mucous membranes
- Weight Loss*
  *Consider age and size of patient

Treatment/Increased Length of Stay

- IV or IM antiemetics
- IV rehydration
  - Greater than maintenance
  - Consider age and disease
  - Restarted or remained in longer than expected
- NG tube placement

Physician Documentation

- Signs and symptoms
- Treatment
- Response to treatment
- Unable to discharge patient due to nausea and vomiting
- May order I&O
- May order daily weights
- Clinical findings on examination

These guidelines are for coding assistance only and are not to be used in determinations for appropriate level of care. They are not meant to replace the official coding guidelines contained in Coding Clinic but are to be used as a tool for determining if documentation supports coding a condition. The use of physician queries is suggested to clarify ambiguous documentation.
DVAC Coding Guideline:
Postoperative Ileus

It is not unusual for a patient to experience some ileus (bowel obstruction) following gastric and abdominal surgery involving extensive handling of the bowel or prolonged use of narcotics. All patients require care and observation following surgery. When the patient has experienced significant symptoms that require more than routine care or extends the length of stay, the coding of postoperative ileus may be appropriate. The physician’s documentation should link the diagnosis to the procedure before a complication code is assigned. The physician’s documentation should demonstrate that ileus is present and more than anticipated in the post surgical period. Documentation of bowel rest alone may not be indicative of ileus.

Signs and symptoms
- Abdominal distention/bloating
- Abdominal pain (lasting 48 to 72 hours postoperative)*
  *take into consideration the age of patient and type of procedure
- Lack of resumption of bowel function
- Lack of bowel sounds
- Lack of flatus
- Prolongation before resumption of normal diet
- Persistent nausea and vomiting

Major Risk Factors
- Narcotics
- GI surgery/Excessive intraoperative bowel handling
- Obesity
- Anesthesia/Nitrous Oxide
- Diabetic gastroparesis
- Elderly
- Abdominal trauma

Treatment/Increased Length of Stay
- Abdominal x-ray (optional)
- Insertion/reinsertion/prolonged use NG tube
- Bowel rest/NPO
- Reversal of diet
- IV fluids/TPN
- Antiemetics
- Motility drugs
- H2 blockers

Physician Documentation
- Signs and symptoms
- Treatment
- Response to treatment
- Unable to discharge patient due to ileus
- May order I&O
- Clinical findings on examination

These guidelines are for coding assistance only and are not to be used in determinations for appropriate level of care. They are not meant to replace the official coding guidelines contained in Coding Clinic but are to be used as a tool for determining if documentation supports coding a condition. The use of physician queries is suggested to clarify ambiguous documentation.
DVAC Coding Guideline:
Postoperative Atelectasis

It is not unusual for a patient to experience some atelectasis following upper abdominal or thoracic surgery. All patients require care and observation following surgery. When the patient has experienced significant symptoms that require more than routine care or extends the length of stay, the coding of postoperative atelectasis may be appropriate. The physician's documentation should link the diagnosis to the procedure before a complication code is assigned. The physician's documentation should demonstrate that atelectasis is present and more than anticipated in the post surgical period. Postoperative atelectasis may be an incidental x-ray or physical finding, in which case it would not be coded or reported.

Signs and symptoms
- Dyspnea
- Diaphoresis
- Cough
- Tachycardia
- Fever within 48 hours of surgery
- Retractions
- Oxygen Satuations less than 89%
- Hypotension
- Clinical findings
  - Rales
  - Rhonchi
  - Wheezes
  - Decreased breath sounds
  - Dullness/flatness on percussion/auscultation
- Cyanosis
- Anxiety

Major Risk Factors
- Narcotics
- Tobacco abuse
- Obesity
- Pulmonary disease

Treatment/Increased Length of Stay
- Chest x-ray
- Respiratory Therapy
  - CPT
  - Incentive Spirometry (ordered by physician)
  - Suctioning
  - Postural drainage
  - Nebulizer treatments
  - CPAP
- Bronchoscopy
- Oxygen
- Antibiotics

Physician Documentation
- Signs and symptoms
- Treatment
- Response to treatment
- Unable to discharge patient due to atelectasis
- Clinical findings on examination

These guidelines are for coding assistance only and are not to be used in determinations for appropriate level of care. They are not meant to replace the official coding guidelines contained in Coding Clinic but are to be used as a tool for determining if documentation supports coding a condition. The use of physician queries is suggested to clarify ambiguous documentation.
DVAC Coding Guideline:
Postoperative Urinary Retention

It is not unusual for a patient to experience some urinary retention (inability to void) following pelvic or perineal surgery. All patients require care and observation following surgery. When the patient has experienced significant symptoms that require more than routine care or extends the length of stay, the coding of postoperative urinary retention may be appropriate. The physician’s documentation should link the diagnosis to the procedure before a complication code is assigned. The physician’s documentation should demonstrate that urinary retention is present and more than anticipated in the post surgical period. Documentation of failed voiding trials may not be indicative of postoperative urinary retention.

Signs and symptoms
• Inability to void
• Decreased urine output with adequate intake
• Abdominal pressure and/or pain
• Dull sound over bladder
• Bladder/abdominal distention
• Residual urine (specific amount as determined by facility policy or attending physician directive)
• With all of these symptoms the age and size of the patient need to be taken into consideration

Treatment/Increased Length of Stay
• Reinsertion of foley catheter due to inability to void
• Urology/Internal Medicine consult due to inability to void
• Extended length of stay
• Straight cath. (# of times and significance as determined by facility policy or attending physician directive)

Physician Documentation
• Signs and symptoms
• Treatment
• Response to treatment
• Unable to discharge patient due to urine retention
• May order I&O
• Clinical findings on examination

These guidelines are for coding assistance only and are not to be used in determinations for appropriate level of care. They are not meant to replace the official coding guidelines contained in Coding Clinic but are to be used as a tool for determining if documentation supports coding a condition. The use of physician queries is suggested to clarify ambiguous documentation.