Part B Insider (Multispecialty) Coding Alert

YOUR PART B QUESTIONS ANSWERED: Keep Flaps Straight for Proper Code Selection

Question: Our surgeon performs an abdominal closure using left and right myofascial advancement flaps. I believe we should code one unit of 15734 because flap codes refer to the recipient area -- not donor site. But the surgeon believes we should code 15734 x 2 because he uses two flaps to perform the defect closure. What is the correct coding?

Answer: You should not report 15734 (Muscle, myocutaneous, or fasciocutaneous flap; trunk) for this service -- either once or twice. Instead, you should list the procedure using an adjacent tissue transfer code such as 14000 (Adjacent tissue transfer or rearrangement, trunk; defect 10 sq cm or less) or 14001 (... defect 10.1 sq cm to 30.0 sq cm) depending on the defect size.

Here's why: Adjacent tissue transfer rearrangement includes repair by advancement flaps, according to CPT instruction in the introduction to those codes. On the other hand, 15734 does not specifically include myofascial flaps and does not describe advancementflaps for closure.

Size matters: Rather than coding this twice, you should code the entire size of the primary and secondary defects (including secondary defects for both flaps). If the defect is larger than 30.0 cm, you can still use the adjacent tissue transfer or rearrangement codes by listing 14301 (Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm) and adding +14302 (... each additional 30.0 sq cm, or part therof) as needed.

Remember Primary Dx Code for These Diabetics

Question: I have a puzzling claim in front of me. The notes indicate that the nonphysician practitioner (NPP) provided a levelthree E/M service for a patient with "secondary diabetes with renal manifest." Do I have enough information to choose a diagnosis code with these notes?

Answer: You've got enough there to choose 249.40 (Secondary diabetes mellitus with renal manifestations, not stated as uncontrolled, or unspecified) for the patient's secondary diabetes.

The 249.40 code reveals two elements: The patient has diabetes, and the diabetes is causing additional physiological issues (in your patient's case, renal manifestations). But you need at least two elements to paint a complete diagnosispicture for these patients.

In the descriptor below 249.40,it says "Use additional code to identify manifestation."

So let's say that the patient is suffering from Kimmelstiel-Wilson syndrome. On the claim, you'd report the following:

• 99283 (Emergency department visit for the evaluation and management of a patient, which requires 3 key components: an expanded problem focused history; an expanded problem focused exam; and moderate medical decisionmaking ...) for the E/M

• 249.40 (Secondary diabetes mellitus with renal manifestations,not stated as uncontrolled, or unspecified) appended to 99283 to represent the patient's diabetes, followed by

• 581.81 (Nephrotic syndrome; with other specified pathological lesion in kidney; nephrotic syndrome in diseases classified elsewhere) appended to 99283 to represent the renal manifestation.

Nervous Patient? Check 796.2

Question: We have a patient who was diagnosed with white coat hypertension. Is there an ICD-9 code for this?

Answer: Use 796.2 (Elevated blood pressure reading without diagnosis of hypertension) as your ICD-9 code. Remember that white coat hypertension (WCH) is diagnosed only when a patient has elevated blood pressure (BP) in the clinic setting but otherwise has normal BP outside the office.

According to Medicare Claims Processing Manual, Chapter 32, Section 10,WCH should be suspected when a patient has all three of the following:

1. Clinic/office blood pressure greater than140/90 mm Hg on at least three separate clinic/office visits with two separate measurements made at each visit

2. At least two documented separate blood pressure measurements taken outside the clinic/office that are less than 140/90 mm Hg

3. No evidence of end-organ damage.

To establish a diagnosis of white coat hypertension, the patient undergoes ambulatory blood pressure monitoring (ABPM).

Medicare will cover ABPM only for patients with WCH. In addition, ABPM must be done for at least 24 hours to meet coverage criteria. A device stores the 24-hour measurements so the physician can interpret them. "In the rare circumstance that ABPM needs to be performed more than once for a beneficiary, the qualifying criteria described above must be met for each subsequent ABPM test," the manual states.

CPT: The following codes describe ABPM:

• 93784 -- Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer; including recording, scanning analysis, interpretation and report

• 93786 -- ... recording only

• 93788 -- ... scanning analysis with report

• 93790 -- ... physician review with interpretation and report.

Check If Exceptions Exist in Fracture Modifiers

Question: An established patient reports to the doctor with an injured right finger he suffered during a skiing accident. The physician diagnoses a closed metacarpal fracture, which he resets using manipulation and places in a plaster cast. The physician tells the patient to follow up with an orthopedist for continuing care. Notes indicate a level-two pre-procedure E/M service. Whatmodifier should I append to the E/M code?

Answer: Most insurers will want to see modifier 57 (Decision for surgery) on the E/M. There are exceptions, however. Medicare, and a number of private payers, prefer modifier 57 each time the physician provides definitive fracture care and an E/M in the same encounter.

For these payers, report the following:

• 26605 (Closed treatment of metacarpal fracture, single; with manipulation, each bone) for the fracture care;

• modifier 54 (Surgical care only) appended to 26605 to show that you are coding the procedure only and not coding for the follow- up care;

• 99212 (Office or other outpatient visit for the evaluation and management of an established patient ...) for the E/M service;

• modifier 57 appended to 99212 to show that the E/M and fracture care were separate services and that the E/M service resulted in the initial decision to perform the procedure;

• 815.00 (Fracture of metacarpal bone[s]; closed; metacarpal bone[s], site unspecified) appended to 26605 and 99212 to represent the patient's injury; and

• E003.2 (Activities involving ice and snow; Snow [alpine] [downhill] skiing, snow boarding, sledding, tobogganing and snow tubing) appended to 26605 and 99212 to denote the activity that led to the injury.