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April 1, 1996

Maurine G. Spillman
Senior Policy Analyst
Department of Physician Payment Systems
American Medical Association
515 North State Street
Chicago, IL 60610

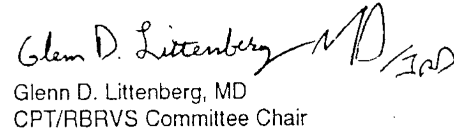
Re: Correct Coding Initiative -- Phase 1 Review of 951 Disputed Coding Pairs

Dear Ms. Spillman:

On behalf of the American Society of Internal Medicine (ASIM), I am pleased to submit the enclosed comments on the Medicare Correct Coding Initiative Phase 1 Review of 951 Disputed Coding Pairs.

Thank you for full consideration of these comments

Sincerely,



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AMERICAN SOCIETY OF INTERNAL MEDICINE

COMMENTS ON THE MEDICARE CORRECT CODING INITIATIVE

PHASE I REVIEW OF 951 DISPUTED CODING PAIRS

APRIL 1, 1996

The following are the American Society of Internal Medicine's (ASIM) comments on several of the 951 coding pairs left out of the first phase of the Health Care Financing Administration (HCFA) Correct Coding Initiative (CCI) for the Medicare program. ASIM is pleased that HCFA has asked a panel developed by the American Medical Association (AMA) to decide whether the disputed codes should or should not be included in the next phase of the initiative.

The following comment pertains to 46 digestive disease coding pairs found on pages 100-125 in attachment 4:

446: 43202-91105, 448: 43204-91105, 450: 43205-91105, 452: 43215-91105, 454: 43216-91105, 456: 43217-91105, 458: 43219-91105, 460: 43220-91105, 462: 43226-91105, 463: 43227-91105, 465: 43228-91105, 467: 43229-91105, 469: 43241-91105, 470: 43243-91105, 471: 43244-91105, 473: 43245-91105, 475: 43246-91105, 477: 43247-91105, 479: 43248-91105, 481: 43250-91105, 483: 43251-91105, 484: 43255-91105, 486: 43258-91105, 488: 43259-91105, 499: 44361-91105, 502: 44363-91105, 504: 44364-91105, 506: 44365-91105, 507: 44366-91105, 509: 44369-91105, 511: 44372-91105, 513: 44373-91105, 514: 44376-91105, 516: 44377-91105, 517: 44378-91105, 518: 44380-91105, 519: 44382-91105, 520: 44385-91105, 521: 44386-91105, 522: 44388-91105, 523: 44389-91105, 524: 44390-91105, 525: 44391-91105, 527: 44392-91105, 528: 44393-91105, 530: 44394-91105.

The entire series code pairs for upper GI endoscopy, small bowel endoscopy and colonoscopy codes listed with 91105, gastric intubation and aspiration or lavage should not be bundled together. As described in our previous comments (see attached), gastric intubation is not linked to the performance of endoscopy or colonoscopy, but is performed either for the evacuation of retained blood or food, or for removal of ingested poisons. Even in the former situation, it is a procedure separate from either a diagnostic or therapeutic endoscopy procedure, and should not require either a -GB modifier, nor be processed with a -51 modifier or subjected to payment reduction rules. The code 91105 is not a service in any way inherent to an endoscopy. There are rare times when both codes would be reported the same day. For example, when evacuating blood clots out of the stomach in order to facilitate performing endoscopy; or delivering a bowel purge (prep fluid) if patient cannot swallow the fluid, in which case with rare exceptions nursing would place the NG tube for this purpose and physician would not report the gastric intubation service separately. In either of these examples, the procedure is typically done well before the endoscopy procedure is started and commonly in a different unit than the endoscopy unit.

The following comment pertains to 36 digestive disease coding pairs found on pages 100-126 in attachment 4:

445: 43202-43227, 447: 43204-43227, 449: 43205-43227, 451: 43215-43227, 453: 43216-43227, 455: 43217-43227, 457: 43219-43227, 459: 43220-43217, 461: 43226-43227, 464: 43278-43227, 466: 43239-43255, 468: 43241-43255, 472: 43245-43255, 474: 43246-43255, 476: 43247-43255, 478: 43248-43255, 480: 43250-43255, 482: 43251-43255, 485: 43258-43255, 487: 43259-43255, 489: 43400-43244, 499: 44361-44366, 501: 44363-44366, 503: 44364-44366, 505: 44365-44366, 508: 44369-44366, 510: 44372-44366, 512: 44373-44366, 515: 44377-44378, 526: 44392-44391, 529: 44394-44391, 531: 45305-45317, 532: 45380-45382, 533: 45383-45382, 534: 45385-45334, 535: 45385-45382.

This second series of code combinations are variants of linking "control of bleeding" with various other modalities of endoscopy. In none of pairs, cited above, should the codes be considered bundled. CPT language and carrier policy should make it clear that if a modality like polyp removal or biopsy is performed and reported, then control of bleeding should not be reported for treatment of the same site, even if bleeding results from the polyp removal or biopsy and during the same session. Further actions must be taken to treat bleeding. In reality, in the unusual circumstance where one modality is reported and treatment of bleeding is also reported, a second site is the appropriate assumption by the carrier. Requiring use of a -GB modifier may clarify the situation, but should not be required. Payment rules would usually involve the "family of codes" rules, whereby the more complex reported procedure is paid at full rate, the secondary procedure is reported and paid at the rate to reflect the difference between the secondary procedure and the "base code" within the family of codes. In this group of codes, there are coding combinations that will virtually never occur because the treatment of bleeding would not be reported on the same day as the modality reported. For example, 43246, placement of gastrostomy tube and 43255, upper gastrointestinal endoscopy with control of bleeding is highly unlikely to occur.

The following comment pertains to page 126 of attachment 4, coding pair 536: 45385 and 46221. This pair should not be considered bundled and would typically not be performed on the same day, but even if performed the same day, are quite separate procedures. Colonoscopy proximal to splenic flexure with polypectomy is performed under IV conscious sedation using flexible fiberoptic instruments; hemorrhoidecectomy by ligature is performed with different typically rigid instruments, with or without local anaesthetic, typically in a different patient position, and does not involve removal of related lesions (polyps) or use of a related technique (snare polypectomy vs rubber band ligation). There is no connection between the two procedures. Very minor facility savings might be incurred by doing both procedures the same day--one set of patient consent and registration paperwork, as well as one recovery period, but all other costs, including all professional work and procedure costs are separate and additive.

The following comment pertains to page 113 of attachment 4, coding pair 489: 43400 and 43244. The former code (ligation, direct, esophageal varices) would normally involve an open thoracotomy or open abdominal surgery with surgical ligation of varices. The latter (UGI endoscopy with band ligation of varices) is an endoscopic exam. It would be quite rare that both procedures would be performed the same day by the same or different physicians; and procedure reports would normally need to be reviewed before considering payment for both procedures separately. These are not "bundled" in the sense that they are one procedure, or one part of the other.

The following comment pertains to page 72 of attachment 4, coding pair 339: 33208 and 93014. These codes should not be bundled. The first code reflects the pacemaker insertion. The second code is a monitoring technique for an ambulatory patient of an EKG strip or strips transmitted at one or multiple times by a Holter-like recorder. Equipment, place of service, service details and physician work are

entirely different for these services.

The following comment pertains to page 204 of attachment 4, coding pair 918: 91012 and 91032. As we mentioned in our previous comments, these codes should not be bundled. 91012 is a motility study in which a nonambulatory patient is studied with a multi-lumen perfused device, recording esophageal pressure and symptoms during swallows and during perfusion of acid. The 91032 study involves a separate device with pH probes and is used to monitor a patient, whether for several hours in the lab or ambulatory, for spontaneous reflux episodes as reflected by pH changes. There are times both codes may be reported the same day, but the professional work involved in catheter passage, placement, equipment use, review of recordings and preparation of reports are separate and additive for the procedures. The -GB rules shouldn't apply, nor should the family of code rules. Reduction of payment rules under -51 modifier shouldn't apply to these distinctly different procedures either.

The following comment pertains to page 204 of attachment 4, coding pair 919: 91030 and 91032. Similar to our comments on coding pair 918 above, these codes should not be bundled. The former is a test in which acid or saline is dripped down an NG tube with the patient's response (pain or no pain) recorded with a standard protocol. The pH test is as described above, involves a different NG catheter, a recording device and looks for spontaneous pH change, with the patient recording symptoms in a diary (in some methods). Again, the professional work involved are quite separate and additive, even if both procedures are performed the same day. The -GB modifier rules shouldn't apply to this coding pair, nor should the family of code rules. Reduction of payment rules under -51 modifier shouldn't apply to either to these distinctly different procedures.

The following comment pertains to 19 coding pairs found on pages 205-209 and page 212 in attachment 4:

922: 92984-93000, 923: 92984-93005, 924: 92984-93010, 925: 93307-93040, 926: 93307-93042, 927: 93308-93040, 928: 93308-93042, 929: 93312-93040, 930: 93312-93042, 931: 93313-93040, 932: 93313-93042, 933: 93314-93040, 934: 93314-93042, 935: 93320-93040, 936: 93320-93042, 937: 93321-93040, 938: 93321-93042, 944: 93350-93040, 945: 93350-93042.

The recording and interpretation of an EKG is a separate device, procedure, interpretation and report from the performance of any type of angioplasty, echocardiography or Doppler echocardiography. A rhythm EKG should not be separately reported if the sole purpose is patient monitoring during performance of the angioplasty or echocardiography. It is likely that physicians are not reporting cardiogram recordings done for procedural monitoring. Carrier rules and CPT language changes could clarify this situation. These codes should not be bundled in carrier edits, since the reporting of the EKG code implies that a separate procedure was performed, even if done on the same day. Since reporting monitoring separately from the angioplasty or echocardiogram does not often take place, requirements for -GB or other modifiers are not appropriate.

The following comment pertains to 5 coding pairs found on pages 209-211 in attachment 4:

939: 93350-90780, 940: 93350-90781, 941: 93350-90782, 942: 93350-90783, 943: 93350-90784.

These coding pairs involve IV infusion with various stress echocardiography modalities. It is reasonable that the administration of a pharmacologic agent to create the stimulus to the heart during which the stress response is observed and documented would be included in the service RVUs of the test itself, but IV infusion does not have relative value units (RVUs) for the physician work included in these procedures. The RVU issue needs to be revisited. It is appropriate to separately report medication administration if performed separate from or after the other procedure, using the -GB modifier.

Circumstances might include administration of a drug for chest pain or rhythm disturbance induced by the testing. However, such reports should be unusual.

The following comment pertains to page 128 of attachment 4, coding pair 547:49081-49080 subsequent and initial paracentesis). Normally these codes would not be reported the same day on the same patient. If there is justification for doing a second "tap" the same day, then the -GB modifier would logically be reported.

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