

OUR PERSPECTIVE: Billing Rules for Non Invasive Vascular Studies

Nancy Daoust, CPC, University of Oklahoma, College of Medicine, Tulsa, OK

When I started coding for the Department of Surgery at OU, I discovered that Medicare was denying many of our charges for "Non Invasive Vascular Studies" as "Not Medically Necessary". Knowing that the venous studies were required and medically necessary, we reviewed our denials and discovered that we were not billing the charge in the correct manner in order to comply with our Local Medicare Regulations as set forth in their LCD (Local Coverage Determination). For the purposes of this article, references will be specific to the Oklahoma and New Mexico Medicare LCD. If this is an issue for your practice or facility, the recommendation would be to check with **your** local Medicare carrier in order to determine their policies or LCD's. After much research we have discovered Medicare Carriers websites are not all uniform.

The extremity venous studies that we do regularly in our office are mostly for patients with End Stage Renal Failure who have been referred for consultation in order to ascertain if they will be a candidate for an arteriovenous fistula (AVF) for permanent dialysis access. To assess the patients arm veins for possible AVF our physician must do a doppler / ultrasound study of the patient's veins, including responses to compression and other maneuvers. Our physician uses this duplex scan to map the patient's veins in order to find viable veins for the creation of the fistula.

Some of the procedures that would require this doppler / ultrasound study are:

36819: Arteriovenous anastomosis, open; by upper arm basilic vein transposition

36820: Arteriovenous anastomosis, open; by forearm vein transposition

36821: Arteriovenous anastomosis, open; direct, any site (eg, Cimino type) (separate procedure)

36825: Creation of arteriovenous fistula by other than direct arteriovenous anastomosis (separate procedure); autogenous graft

It is to be noted that none of the above procedures are subject to a Medicare LCD and all are billable with a diagnosis code of 585 among numerous other diagnoses.

We routinely use CPT codes 93970 & 93971 for this mapping / duplex scan, and we were billing our charge with a supporting diagnosis of 585 or Chronic Renal Failure. Our claims were being denied as "not medically necessary" because the diagnosis 585 (Chronic Renal Failure, which is an acceptable diagnosis for the performance of the procedure) is not approved in the LCD of our local Medicare carrier as a supporting diagnosis. After researching this matter and speaking to different customer service agents at our local Medicare office, we were led to code V45.1 "Renal Dialysis Status". In order for your charge for the duplex scan to process with Medicare, contrary to CPT rules which state that this code is not a primary diagnosis, it must be listed as the primary diagnosis for your duplex scan.

The reason I mentioned for you to check your own LCD is because in some regions the supporting diagnosis is different. For example, in Chicago, Colorado and Florida the supporting diagnosis that would be used would be V72.83 which is "other preoperative specified examination", which one would think would be a justifiable

supporting diagnosis for any Medicare region, but it is not.

Did you know a perfect new code for Vessel Mapping G0365 became effective 01/01/05? The HCPCS description of this code is "vessel mapping of vessels for hemodialysis access (services for preoperative vessel mapping prior to creation of hemodialysis access using an autogenous hemodialysis conduit, including arterial inflow and venous outflow)". This code's description specifies that it is to be used for Vessel Mapping for hemodialysis access, and the understanding was that we would use this code if the patient had never had a prior AVF. Yet, if you look at the LCD for Oklahoma, there is no diagnosis listed that would support medical necessity of this procedure. Therefore, if Medicare is billed, the charge will be denied as "not medically necessary". As a matter of fact our LCD states we can use G0365 for complications of a vascular device or graft which is a contradiction to what we understood the use of this procedure was. What is needed is a supporting diagnosis such as 585 "Chronic Renal Failure" with V45.1 "Renal Dialysis Status" or V72.83 "other preoperative specified examination".

We question why regions like Wisconsin, Michigan, Illinois, St Louis, and Chicago, allow via their LCD, the supporting diagnosis of 585 "Chronic Renal Failure" and V72.83 "other pre operative specified examination" and yet here in Oklahoma our LCD almost prohibits the use of this code because the allowable supporting diagnosis contradicts the definition of this procedure.

CPT code 93990 is used for a duplex scan of a hemodialysis access. This CPT code is only allowed by Medicare if there is some type of complication of a previous vascular device implant or graft which includes AVF, shunt, or dialysis catheter. If a complication diagnosis like 996.1, 996.62, 996.73 and 996.74 is used, then, this procedure code will be reimbursed. Some of the procedures that would require the use of this duplex scan are:

36831: Thrombectomy, open, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft (separate procedure)

36832: Revision, open, arteriovenous fistula; without thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)

36833: Revision, open, arteriovenous fistula; with thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)

36834: Plastic repair of arteriovenous aneurysm (separate procedure)

37607: Ligation or banding of angioaccess arteriovenous fistula

The noted procedures are also subject to Medicare LCD's which include the same complication diagnosis codes 996.1, 996.62, 996.73 and 996.74 as well as 440.31, 440.32, 442.0, 442.3, 444.21, 444.22, 447.1, 453.8, and 459.2. Code 37607 is not subject to a Medicare LCD but still requires a complication diagnosis of 996.73, 996.74, V53.90, V53.99 and V58.91.

Another important aspect when billing any of the above mentioned non invasive vascular tests is with respect to "Place of Service". If we use our own ultrasound machine and the procedure is performed in our office, we are reimbursed the full allowable fee by Medicare. However, if the procedure is performed at a facility or hospital, (even if you bring your own ultrasound machine for utilization) then only the -26 modifier component

(Professional Component) will be reimbursed. If you bill Medicare without this modifier and the place of service is not your office, Medicare will deny payment.

There are many other procedures, tests or studies that the discussed rules would apply to. If your office has encountered similar problems being reimbursed for certain procedures or tests we can only suggest that you check your LCD's via Medicare's website or call their customer service department. We have always found Medicare's agents to be very helpful in discussing the various issues. Always note that one cannot simply add a diagnosis to the charge billed for it to be paid within your LCD. Any diagnosis added must actually be found in the patient's medical record.

Of course, there are certain procedures, tests and studies that are simply not paid for by Medicare. In these instances or in instances when you are not sure if the billable service will be covered, one should always obtain an ABN (Advance Beneficiary Statement) from the patient and bill your charge to Medicare with the -GA modifier, which would allow patient billing for the service if denied by Medicare.