Briefings on APCs

This month’s coding Q&A

Medical necessity

Q: The office of inspector general often audits for medical necessity. Why do you think it's such a common problem?

A: There can be a disconnect between the healthcare professional, the physician's opinion of what's medically necessary, and what the third-party payer finds to be medically necessary.

And as coders, I want you to remember the importance of including explanations and documentation. For example, a patient having a mole removed. If you don't include the fact that the patient has Parkinson's disease, payers are not going to consider having them admitted as an inpatient or any kind of sedation or anesthesia as medically necessary. They either won't pay for the whole thing, or they won't pay for that part.

It’s very important for us to remember that we have to make sure that we tell the whole story. You may have a patient that comes in every month for something, for example, an injection. Whatever it might be, because you know this person and you know their particular circumstances, it might be easy to overlook something, so it's not included in the documentation for the visit.

Editor’s note: Shelley C. Safian, PhD, RHIA, MAOM, CCS-P, CPC-I*, an AHIMA-approved ICD-10-CM/PCS trainer and president of Safian Communications Services Inc., answered this question during the HCPro webinar, “Medical Necessity: ICD-10-CM Coding and Reimbursement.”*

Monitoring of interstitial fluid pressure

Q: What is the code for a pressure monitor machine used to get a continuous reading of compartment pressure on fractures?

A: If used during the postoperative period, this service would be included in the global surgical package and not separately reported. Otherwise, use the unlisted code for the specific anatomy. Do not use CPT® code 20950 because the pressure monitor machine performs a noninvasive procedure, operating similarly to a blood pressure device. CPT code 20950 represents an invasive procedure.

Medicare’s CCI policy manual instructs, “Some procedures routinely utilize monitoring of interstitial fluid pressure during the postoperative period (e.g., distal lower extremity procedures with risk of anterior compartment compression). CPT code 20950 (monitoring of interstitial fluid pressure) shall not be reported separately for this monitoring.” (CCI, Chapter 4, §I.8)

However, if the procedure was in fact invasive and is not included in the global period for a surgical procedure, be aware that there are differences of opinion on how to bill CPT code 20950. An official with the American Academy of Orthopaedic Surgeons Coding Committee has stated that you’d report CPT code 20950 “once for all four compartments of the leg. Twice if you do leg and thigh or right leg and left leg.”

Medicare limits you to reporting CPT code 20950 just twice on the same patient and same calendar day through a medically unlikely edit, which sets the code’s units of service at 2.

American Medical Association guidance also states that CPT code 20950 should be reported once per leg, regardless of the number of compartments tested.

Check with the specific payer policy on how CPT code 20950 should be reported.

Editor’s note: *This question and answer comes from the book,* 2024 Orthopedic Coding & Documentation Trainer, 2023.

Prolonged service times

Q: CMS’ prolonged service code G2212 was originally based on the maximum times in the descriptors for

CPT codes 99205 and 99215. But the 2024 CPT manual replaced the minimum and maximum time ranges for the office/other outpatient codes with minimum times that the provider must meet or exceed.

Should our practitioners continue to use Medicare's prolonged service times for office/other outpatient E/M visits, or should they switch to the shorter times for prolonged service code 99417 in the 2024 CPT manual?

We believe the times for G2212 still apply, but we want to make sure.

A: You are correct. Your practice should stick with the original times for G2212.

The latest CPT update created confusion because the descriptor for G2212 states that the prolonged time is "beyond the maximum required time of the primary procedure." CMS did not change its descriptor for G2212 in response to the revised CPT code descriptors (*PBN 11/20/23*). This caused many practices to wonder if they could report G2212 based on the time in the CPT code descriptors.

However, the chart at CMS 100-04, Chapter 12, ¤30.6.15.2 still lists the same time thresholds for G2212. According to the chart, the provider must perform at least 89 minutes of time-based services on the date of the encounter to report CPT code 99205 and one unit of G2212. To report one unit of G2212 with CPT code 99215, the provider must perform at least 69 minutes of time-based services.

There are additional signs that CMS is sticking with the rules it originally laid out for G2212. The agency did not mention that it will change or plans to change its prolonged service policy in the final 2024 Medicare physician fee schedule or the proposed 2025 Medicare physician fee schedule. More importantly, it continues to list the prolonged CPT code 99417 as invalid for Medicare payment purposes. If the agency wanted to use the times for the prolonged CPT code it would adopt 99417 and delete G2212.

Editor's note: *This question and answer originally appeared on Part B News.*

These answers were provided based on limited information. Be sure to review all documentation specific to your own individual scenario before determining appropriate code assignment