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While attending the exhibits at the 2013 Symposium on Advanced Wound Care/Wound Healing Society Spring conference, I learned about a fascinating new technology — fluorescence vascular angiography. Currently, numerous approaches are used to determine vascular flow, including the ankle-brachial index test, Doppler measurement, duplex ultrasound scanning, arteriogram, toe systolic pressure index, transcutaneous oxygen measurement, and other more invasive procedures such as computed tomography fluoroscopy. While similar to these procedures, fluorescence vascular angiography provides qualified healthcare professionals (QHPs) with real-time arterial blood flow to an ulcer, capillary perfusion within the tissue in question, and venous outflow (including potential congestion as well as the most current degree of necrosis). This technology allows wound care QHPs to assess microvascular blood flow and microvascular perfusion in extremities. It is ideal for assessment of both arterial and venous issues, selection for hyperbaric oxygen therapy, interventional surgery, limb salvage, and serial assessment of wound healing and wound care effectiveness. (For more information on this subject, see “Product Spotlight” on page 22.)

It’s probably no surprise that I had many reimbursement questions regarding fluorescence vascular angiography. The manufacturer was kind enough to answer all of my questions. This article shares these reimbursement questions and answers.

Q: Hospital-based outpatient wound care departments (HOPDs) will want to know if a code exists for the use of fluorescence vascular angiography in their site of service. Have the Centers for Medicare & Medicaid Services (CMS) established a Healthcare Common Procedure Coding System code for the procedure?

A: Yes, in April 2012 CMS established the temporary pass-through code: C9733 Non-ophthalmic fluorescent vascular angiography.

Q: Has C9733 been assigned to an ambulatory payment classification (APC) group?

A: Yes, C9733 has been assigned to APC group 0397 since April 2012. Therefore, C9733 is separately billable when used in HOPDs. CMS did assign the Q2-status indicator: no separate payment is provided when billed with procedures that are assigned a T-Status indicator, eg, surgical debridement (11042-11047), application of skin substitutes (15271-15278), removal of devitalized tissue (97597-97598), negative pressure wound therapy (97605-97606), and negative pressure, not durable medical equipment (G0456-G0457). Some common wound care services/procedures that do not have a T-status indicator are: application of rigid leg cast (29445), application of paste boot (29580), application of multilayer compression (29581-29584), dressing (29585-29586), application of adhesive bandage (29587), application of paste bandage (29588), application of water sheet dressing (29589), application of dressing (29590), negative pressure wound therapy (97605-97606), and hyperbaric oxygen (C1300). See Table I for the 2013 APC payment rates.

Q: Some wound care physicians may wish to use this technology in an ambulatory surgery center (ASC). Is this procedure separately payable in ASCs?

A: CMS assigned the N1-status indicator to C9733 when performed in an ASC. That status indicator tells wound care QHPs that C9733 is considered a packaged service/item that does not have separate payment when used in the ASC.

Q: What Current Procedural Terminology (CPT®) code should QHPs use when they perform this procedure?

A: Like other new medical services, no Level I CPT code currently exists that specifically describes the non-ophthalmic fluorescence vascular angiography. Until such time that a specific CPT code is established, CPT coding conventions require that these procedures be reported using an “unlisted procedure” CPT code. Whenever reporting a service using an unlisted CPT code, it is strongly recommended that the freeform field of the CMS 1500 claim form (Field 19, “reserved for local use,” which is 61 characters in length) be
Q: Does Medicare typically cover fluorescence vascular angiography for patients living with chronic wounds, and do any local coverage determinations exist pertaining to this procedure?

A: In the absence of a local or national coverage determination, the local Medicare Administrative Contractor (MAC) will determine whether coverage is available for fluorescence vascular angiography on a case-by-case basis. CMS requires all MACs to manually review all claims submitted with unlisted procedure codes. Therefore, it is recommended that prior to any claim submission that QHPs directly contact their MAC to establish definitive coding direction and intended payment amounts for fluorescence vascular angiography procedures. Failure to do so may result in unnecessary claim rejection and denials. This will require that QHPs write to their respective MAC and express their coding and relative value unit recommendations. Direct physician interaction with MACs is critical to proactively ensure they fully understand the fluorescence vascular angiography procedure.

Q: Do private payers cover fluorescence vascular angiography for patients living with chronic wounds?

A: Private payer coverage depends on the patient's insurance plan. Before using fluorescence vascular angiography for a particular patient, the QHP should verify the patient's insurance benefits and obtain written prior authorization, when required. QHPs should keep in mind that prior authorization is never a guarantee of payment. To prior-authorize fluorescence vascular angiography before the procedure is rendered, the following information should be provided to the payer's prior-authorization department:

- Beneficiary name
- Beneficiary address
- Beneficiary ID number
- Date of birth
- ICD-9-CM diagnosis code
- CPT procedure code
- Requesting physician
- Requesting physician address
- Insurer tax identification or provider name
- Facility name
- Facility address
- Date of service

TABLE 2. Items to Consider Documenting as Part of Medical Necessity

1. Document that the patient has critical limb ischemia with tissue loss based on non-invasive studies and physical examination and that the patient has inoperable disease that cannot be dealt with percutaneously or with additional surgery and why. In addition, document detailed wound care that the patient has had and how it has been unsuccessful.

2. Document patient has critical limb ischemia with tissue loss and has no surgical or percutaneous options:
   a. Patient has failed prolonged medical therapy and wound care (document both) and is facing amputation.
   b. Outline that the level of amputation is difficult to determine because of unreliable ankle-brachial indexes due to calcified non-compressible vessels.
   c. Document that a computed tomography scan has been done that demonstrates inoperability. This then leads into why fluorescence vascular angiography should be performed to help delineate the perfusion to the foot or lower extremity to help determine the level of amputation (ie. toe, tranmet, bka, aka, etc.)

3. Document that without fluorescein vascular angiography, imaging it is likely that the patient will receive a higher level of amputation while the fluorescence vascular angiography procedure would suggest the best level, and therefore save additional procedures should the non-fluorescence vascular angiography directed amputation fail and has to be revised.

4. Document that fluorescence vascular angiography was used successfully to assess perfusion in response to or for selection of therapy (hyperbarics, revascularization, skin graft, other).
Q: What type of documentation is typically required to prove medical necessity for fluorescence vascular angiography?
A: All payers will require supporting clinical documentation, which should include:
• Detailed patient history with description of patient’s current status, including diagnosis, complaints, and level of impairment. Describe functional impairments, and how the patient’s condition has impacted his/her activities of daily life.
• Previous treatment efforts — note procedures, medications, and/or therapies attempted; include outcome of each treatment.
• The medical necessity and rationale for fluorescence vascular angiography, eg, specifics substantiating why this procedure is an appropriate option at this point in the patient’s care, therapeutic goals and anticipated outcomes, and risk to patient if procedure is not performed.
• Description of the procedure.
• Clinical benefits of the procedure, eg, how fluorescence vascular angiography will impact physician management of the patient, anticipated improvement in outcomes, etc.
• FDA clearance letter for the procedure.
• Operative report (if the QHP performed one).
• Clinical references supporting the appropriateness and efficacy of the procedure.

See Table 2 for items to consider documenting as part of medical necessity.

Q: Has Medicare specified diagnosis codes that it deems prove medical necessity?
A: No, Medicare has not provided any diagnosis code guidelines.

Q: Are there any National Correct Coding Initiative (NCCI) edits pertaining to C9733?
A: As of June 2013, there are no NCCI edits pertaining to C9733. However, remember that the Q2 APC-status indicator prevents payment of C9733 when procedures assigned T-status indicators are performed.

Q: I understand that plastic and reconstructive surgeons also use this technology in the operating room (OR). Is there an ICD-9-CM procedure code for the work performed in the OR?

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Wound Care Revenue Cycle Insights: Multiple Viewpoints

Don’t miss this entirely new 2013 program that highlights all the changes you must implement.

New Program and Format for 2013
To accommodate the requests from previous years’ attendees and to address the numerous 2013 “hot reimbursement topics,” our faculty has changed the format of Wound Clinic Business 2013. It will be composed of a series of interactive discussions from the viewpoint of the hospital-based outpatient wound care departments (HOPDs), and the qualified wound care professionals who manage wounds in the HOPD and their offices.

Who Should Attend? The evaluations from all previous years have one resounding message: “This was the best wound care reimbursement seminar — I only wish people on my team had attended.” Therefore, plan to bring your entire team so that everyone has the benefit of participating in the interactive discussions: medical directors, physicians and podiatrists, non-physician practitioners, HOPD program directors, therapists, coders and billers, office managers, charge description master directors, corporate compliance officers, health information management directors, revenue integrity auditors, hospital executives, and clinical managers.

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WCB2013 Dates/Locations

Friday, September 20
Houston, TX
Crowne Plaza Houston Near Reliant Medical

Thursday, September 26
Las Vegas, NV
Bally’s Las Vegas

Friday, October 4
St. Louis, MO
Embassy Suites St. Louis-Downtown

Friday, October 18
San Diego, CA
The Westin Gaslamp Quarter San Diego

Note: Dates and locations subject to change.