

# Anesthesia & Pain Coder's Pink Sheet

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Essential news and guidance to solve your toughest specialty coding challenges

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### New coding guidance

## Use revised post-op block, TEE guidance to introduce changes from ASA

Make sure your team is up to date on changes in the 2016 Relative Value Guide and 2016 Crosswalk, two publications released by the American Society of Anesthesiologists (ASA), to avoid missed revenue opportunities and sudden denial spikes.

Start with the statements and positions related to coding in the Relative Value Guide. They're now available online and organized by topic and in order of latest revision date, but you'll want to hang on to your 2015 RVG guide.

(see **ASA**, p. 7)



### Getting paid

## Those drug screen denials explained — all drug claims on hold until April

Don't submit claims that include one of the new drug screen codes (**G0477-G0483**) before April 4. The entire claim — and your money — will sit in limbo until CMS lifts its hold on drug screen claims.

According to a CMS announcement on Jan. 28, a system error is the cause of the problem, but the agency didn't provide details. Before the announcement, readers were reporting denials of direct optical observation drug screen code **G0477**

(see **hold**, p. 6)

### Drug screen coding



Confused by drug screen coding? Have questions about your presumptive or definitive drug screen tests? Register now for **Drug screen update 2016: Learn to use the Medicare's new codes to protect your revenue** <http://www.decisionhealth.com/conferences/a2650>, Feb. 18, 1-2:30, p.m., E.T. To register by phone: 1-855-CALL-DH1. This webinar has been approved for 1.5 CEUs.

## Quality reporting

### Look to registry reporting now; be ready when CMS releases the 2016 list

Practices need to weigh the cost of alternative quality reporting methods against the risk of flubbing quality reporting in 2016. This year, any group that employs at least one physician could face a combination of cuts totaling 6%, based on quality reporting.

Currently the majority of providers who participate in the physician quality reporting system (PQRS) program use claims-based reporting, according to the 2016 Medicare physician fee schedule. The key advantage of claims-based reporting is it's free, says Jennifer Searfoss, president and CEO of SCG Health, Ashburn, Va.

However, PQRS and the stakes of reporting have rapidly evolved: What was once a program that gave providers the chance to receive a bonus if they reported three measures became a program that penalized providers who failed to report at least one measure. Now, providers who treat Medicare patients must report nine measures, including one cross-cutting measure, across three national quality domains — noted with shorthand (9[1], 3) — to avoid a 2% penalty on his payments.

In addition, the value-based modifier (VBM) applies to most group practices and is based on the PQRS performance of at least half of the providers under the same tax identification number (*APCPS 11/15*). The VBM could cut up to another 4% from the group's payments based on quality reporting.

Registry reporting, particularly for larger practices, can relieve staff of the effort and time required to make sure the measures codes are appended to each appropriate claim. However, registries aren't free. A practice will need to select and enroll with a registry, enter into an agreement that allows the registry to access the practice's data and comply with the registry's requirements.

### Understand the 2 types of registries

You may hear people refer to qualified registries and qualified clinical data registries (QCDR). They aren't the same thing, although an organization may offer both kinds of registries. Here is an overview of the two types:

**1. Qualified registry.** These registries report CMS-approved PQRS measures. A provider may report individual measures as he would claims-based

measures: 9(1), 3 for at least 50% of all eligible Medicare patients. Expect to pay \$300 to \$500 per provider, said Jeanne Chamberlin, FACMPE, director, MSOC Health, during DecisionHealth's **2016 PQRS Action Plan** webinar.

However, you'll find there are more registry-based measures as CMS continues its shift away from claims-based reporting. For example, the new opioid therapy management measures are registry-only. Similarly, the blood-infection prevention measure (#76) is now the only claims-based measure traditionally associated with anesthesia services. The patient warming and coronary artery bypass graft measures moved to registry-only in 2016.

You can find information on registry measures on CMS' measures code website (*APCPS 2/16*).

In addition, this form of registry reporting is the only way to report measures groups, and providers who choose that method have to report on only 20 patients, so long as at least 11 are Medicare patients, Searfoss notes.

**2. Qualified clinical data registry.** Think of this as registry plus. Providers must report nine measures across three domains, but QCDRs may report PQRS and non-PQRS measures. There is no cross-cutting measure for QCDR, but providers must report outcome measures — measures that show the result of the patient's treatment:

- Two outcome measures.
- One outcome measure and one of the following types of measures:

1. Resource use.
2. Patient experience.
3. Efficiency appropriate use.
4. Patient safety.

In 2016, providers must successfully report quality measures for 50% of eligible Medicare and non-Medicare patients and the cost can range from free to \$10,000 per provider, Chamberlin noted.

### Think about registries now

Each year, registries must re-apply for CMS approval, and the federal agency releases a list of registries in the middle of the current reporting year. There's no guarantee that a vendor that was approved for 2015 will be approved for 2016.

That gives practices time to think about whether registry reporting is a good fit and review the measures that can be reported via registry. Contact a few registries that were approved in 2015 to determine whether they have applied to participate in 2016 and investigate them, so you have a smaller list of organizations to consider with CMS releases the final list. — *Julia Kyles, CPC (jkyles@decisionhealth.com)*

#### RESOURCE:

- ▶ CMS measures codes
- ▶ Registry reporting
- ▶ Qualified clinical data registry reporting

**Editor's note:** *Couldn't make the webinar? You can still ensure your PQRS success in 2016. Visit <http://www.decisionhealth.com/conferences/a2653/index.html> or phone 1-855-CALL-DHI to get on-demand access to the webinar **2016 PQRS Action Plan: Avoid penalties gain revenue, ease reporting.***

## Common coding challenges

### Use 4 post-op block FAQs to strengthen your coding, protect your revenue

Post-op blocks are a major source of revenue for anesthesia practices, but the rules confuse providers and coders, putting their claims at risk.

Share the following four questions from a recent APCPS post-op blocks webinar to prevent denials that can't be appealed:

**Question:** *Is medical direction broken when an anesthesiologist performs a post-operative block?*

**Answer:** Start by checking with your carrier. "Some carriers have published frequently asked questions that state that acute pain management procedures and blocks are OK. Some carriers leave it up to the individual provider's discretion," Kelly Dennis, MBA, ACS-AN, CANPC, CHCA, CPC, CPC-I, president, Perfect Office Solutions, Leesburg, Fla., said during the webinar.

For example, Palmetto released a list of FAQs that indicate post-operative blocks will not break medical direction:

"As long as the medically directing anesthesiologist 'remains physically present and available for immediate diagnosis and treatment of emergencies' (rule 6 of the

CMS 'seven requirements'), we agree that the following procedures would be an illustrative but not exclusive list of allowed interventions ...

"2. Placement of an epidural catheter for post-operative analgesia or in preparation for subsequent surgery (for a 'to follow case')

"3. Placement of other peripheral nerve blocks prior to subsequent surgery, to include brachial plexus blocks, ankle blocks, femoral nerve blocks, etc."

Novitas also allows doctors to run all forms of blocks while medically directing.

"An anesthesiologist may perform and, if otherwise eligible, seek reimbursement for procedures (such as arterial line insertions; central venous catheter insertions; pulmonary artery catheter insertions; and epidural, spinal and peripheral nerve blocks) in an area immediately available to the operating room and when performance of such services do not prevent him/her from being immediately available to respond to the needs of the surgical patients."

Note that both carriers emphasize that the anesthesiologist has to be immediately available to the patients under the care of the certified registered nurse anesthetists (CRNAs) he is medically directing. "Look at where the blocks are being done. Where are the CRNAs?" Dennis said.

Ask a carrier for a written opinion on post-op blocks and medical direction if it hasn't released a statement. "Ask the state anesthesia association or the American Society of Anesthesiologists [ASA] if you want to ask anonymously," Dennis said.

**Question:** *Can orders for post-op blocks be verbal?*

**Answer:** The surgeon may place a verbal order for a post-operative block, but the verbal order must be documented — and they can get lost, Dennis cautioned. The best practice is to get a separate written order from the surgeon. When that doesn't happen, you might be able to find documentation that supports the request in the surgeon's note. Remind anesthesia providers and administrative staff that a block performed without a documented request is a block that can't be billed.

As auditors ramp up their scrutiny of anesthesia services, blocks performed without the request will be an easy target, but it may not take an audit to stop payments. For example, during her presentation, Dennis noted that Cigna will not process a claim for a block without documentation that supports medical necessity.

In addition, practices should review the ASA's guidance on post-op blocks, Dennis said (*see story, p. 1*).

**Question:** *We're receiving denials on hospital visit 99231 reported for post-op block rounds when the anesthesia provider who performed the block bills the visit. The carrier says that in those circumstances, the visit is bundled with the anesthesia care.*

**Answer:** "There are no global days associated with those codes, so you should be able to get paid on appeal," Dennis said.

Denials highlight the importance of creating complete documentation for every service. Without it, there is no way to appeal a denial. Make sure staff understand the requirements for the hospital visit as well as the post-op block.

**Question:** *How do we bill a saphenous block?*

**Answer:** Saphenous blocks don't use a specific code, but it is a peripheral nerve block and may be reported with **64450** (Other peripheral nerve block), Dennis said. — Julia Kyles, CPC ([jkyles@decisionhealth.com](mailto:jkyles@decisionhealth.com))

**RESOURCES:**

- ▶ Palmetto GBA advisory bulletin, August 2011
- ▶ Novitas anesthesia FAQs

**Don't report abductor canal blocks with the peripheral code**

Check with your carrier to make sure, but be aware that it is CPT's position that providers should report adductor canal blocks with femoral block code **64447** for single injections and **64448** for continuous catheterizations, noted Kelly Dennis, MBA, ACS-AN, CANPC, CHCA, CPC, CPC-I, president, Perfect Office Solutions, Leesburg, Fla., during *APCPS's* post-op block webinar.

The guidance was released in CPT Assistant November 2014. Previously, providers used peripheral nerve block code **64450**, Dennis said (*see story p. 3*).

**Editor's note:** *If you didn't make the live webinar, you can still hear the presentation. Call 1-855-DH1 to order your CD and handouts for **Post-op blocks 2016 — Learn to report new blocks, use best practices to preserve your post-op block pay.** Tell the customer care rep you want MPW-A2649CD-16.*



**Getting paid**

**Take a look at the pay for your high utilization codes in a post-SGR world**

The first year without the sustainable growth rate (SGR) has not been without the payment roller coaster you're used to riding. After the permanent fee fix was signed into law, CMS tweaked the 2016 physician and anesthesia conversion factors before the start of the year. After Jan. 1, CMS announced a 14-day claims hold to fix additional problems with the way the relative value file was calculated.

At last the dust has settled and you can take a look at the payments for the top 10 procedure codes reported by anesthesiologists, certified registered nurse anesthetists, pain management and interventional pain management specialists, according to the latest data from CMS.

Code	Description	2015 \$35.9335	2016 \$35.8043	Difference 2015-2016
62311	Inject spine lumbar/sacral	\$226.02	\$226.28	.26
64483	Inj foramen epidural l/s	\$223.51	\$224.13	.62
64493	Inj paravert f jnt l/s 1 lev	\$176.07	\$176.52	.45
64635	Destroy lumb/sac facet jnt	\$422.22	\$426.79	4.57
64636	Destroy l/s facet jnt addl	\$173.92	\$176.52	2.60
77003	Fluoroguide for spine inject	\$86.24	\$86.29	.05
99204	Office/outpatient visit new	\$166.73	\$166.13	-.60
99213	Office/outpatient visit est	\$73.30	\$73.40	.10
99214	Office/outpatient visit est	\$108.88	\$108.13	-.75
99291	Critical care first hour	\$279.20	\$277.48	-1.72



## QUICK CODING CHART

### Paravertebral blocks (PVB) — 64461 and 64462

Share this chart to get your staff up-to-speed on the newest post-op pain injection.

Code	Long descriptor	Plain-English description
<b>64461</b>	Paravertebral block (PVB) (paraspinous block), thoracic; single injection site (includes imaging guidance, when performed).	A thoracic paravertebral block (PVB) or paraspinous block is performed to provide unilateral anesthesia in patients undergoing thoracic or breast surgery or those with chest trauma and rib fractures. The paravertebral space is a wedge-shaped compartment adjacent to the vertebral bodies communicating superiorly and inferiorly across the ribs. The spinal nerves emerge from the intervertebral foramina into the paravertebral space and with the intercostal nerves branch laterally and extend medially into the epidural spaces. A thoracic PVB produces ipsilateral somatic and sympathetic nerve blockage with minimal cardiovascular or respiratory compromise.  Code 64461 reports a single thoracic injection site with imaging, when performed. Code 64462 reports a second and any additional thoracic injection site.
<b>+64462</b>	...; second and any additional injection site(s) (includes imaging guidance, when performed) (List separately in addition to code for primary procedure).	

#### Medicare payment indicators — physician fee schedule 2016

Status code	<b>A</b> = Active code.	
Global days	<b>000</b> = Includes services provided on the day of the procedure.	
Bilateral surgery ( <b>50</b> )	<b>1</b> = The 150% payment adjustment does apply.	
ASA crosswalk	Anesthesia care typically not required	
MUE: <b>1</b>	Adjudication indicator: <b>2</b>	Rationale: <b>Code descriptor</b>

#### Sample ICD-10 codes that may support medical necessity. This list is not all inclusive.

<b>G89.12</b> Acute post-thoracotomy pain	<b>G89.22</b> Chronic post-thoracotomy pain
<b>G89.18</b> Other acute postprocedural pain	<b>G89.28</b> Other chronic postprocedural pain

#### Coder's notes

Share the following descriptor of a single level PVB to help staff understand the documentation that is required to support the service:

With the patient in a supported sitting position or resting lateral decubitus with the side to be blocked in the uppermost position, the spinous processes are marked on the skin and a parasagittal line is measured and drawn lateral to the midline.

The subcutaneous tissue and paravertebral muscles are infiltrated with local anesthetic along the parasagittal line. Using visual and tactile land-marking and ultrasound imaging as indicated, a spinal needle with extension tubing attached to the syringe containing local anesthetic is inserted into the paravertebral space and the anesthetic is injected.

Source: *Correct Coding Initiative 22.0.*

## hold

(continued from p. 1)

with modifier **QW** (Clinical Laboratory Improvement Act-waived test).

The current 2016 clinical lab fee schedule does not allow payment for code **G0477** with modifier **QW**. “This will likely be updated for the second quarter, but it leaves some practices in a bind, in that in order to be paid in the first quarter for G0477, they will need to report without the modifier; but the effective date of the CLIA claims adjudication is Jan. 1 even though the QW modifier doesn’t become effective till April 1,” notes Marvel Hammer, RN, CPC, CCS-P, ACS-PM, CPCO, president, MJH Consulting, Denver.

APCPS noted earlier that the 2016 clinical laboratory fee schedule did not list modifier QW with new drug screen code G0477 but did not receive a response from CMS about the omission (APCPS 12/15).

Based on the notice from CMS, the problem extends beyond the QW modifier and will impact any claim that includes a drug screen code. “Should you wish to avoid your claims from being held, you can remove codes G0477 through G0483 and submit the rest of the services on the claim. When the system is updated in April, you can submit an adjustment claim to add these HCPCS codes,” CMS states. — *Julia Kyles, CPC (jkyles@decisionhealth.com)*

### RESOURCES:

- ▶ CMS drug screen claims hold announcement
- ▶ 100-04, Change Request 9515

### Meaningful use

## Anesthesia excluded, easier exception process and new deadlines for others

Physician groups will be eligible to apply for an exception for multiple eligible professionals (EPs) through a single application, according to an updated hardship-exception protocol released Jan. 22. Previously, all providers had to file an individual exception, even those in the same practice.

That will make it easier for practices to avoid a 3% pay cut in 2017.

“This is very welcome news,” says Rob Tennant, senior policy adviser for the Medical Group Management Association (MGMA) in Washington, D.C., who says providers will see a “significantly streamlined hardship application process” as a result of the program changes.

### Deadline gets pushed up

Forget the July 1 deadline. The new filing deadline is March 15, and the reasons an EP can cite for filing a hardship remain the same, with one addition: hardship exceptions because of the delayed rulemaking issued for the program’s modified stage 2 and stage 3. Providers that are planning to cite the late rulemaking as a cause of hardship should choose subcategory 2.2d on the hardship-exception application.

Another reprieve is a shortened application form. Providers that choose to submit with multiple EPs on a single application will need to provide all national provider identifiers (NPIs) on the form, notes CMS.

Remember that certain specialties — including anesthesiology — are automatically excluded. Be sure to follow best practices when submitting your application, such as submitting by email and storing a receipt.

The relaxed filing process arrives after Congress directed CMS to simplify meaningful use exceptions through the Patient Access and Medicare Protection Act (PAMPA).

### Don’t miss the penalty appeal deadline

EPs that will receive the meaningful use penalty based on their 2014 performance have an earlier deadline. They must submit the appropriate payment adjustment reconsideration application — for single EPs or multiple EPs — together with any supporting documentation by Feb. 29.

“Only apply if you received a letter from Medicare indicating that you are subject to the 2016 payment adjustment,” CMS says. The process is for EPs that feel the penalty assessment was applied in error. The agency strongly encourages EPs to submit the application via email but provides a fax number to be used as a final resort. — *Richard Scott (rscott@decisionhealth.com)* and *Julia Kyles, CPC (jkyles@decisionhealth.com)*

**RESOURCES:**

- ▶ Access the 2017 hardship exception application
- ▶ Access the 2017 filing instructions

**ASA**

*(continued from p. 1)*

This year the ASA tweaked two statements. The information in reporting post-operative pain procedures in conjunction with anesthesia has been rewritten to make it easier to read, but it does not contain the additional guidance that was included in earlier versions of the guide, such as CPT Assistant articles and excerpts from the Correct Coding Initiative (CCI) manual.

This is an opportunity to review the latest CCI guidance with your staff. Pull up your carriers' post-op block policies and look at the CCI manual, Chap. 2 (*APCPS 1/13*). Finish off by walking staff through the three keys to audit-proof post-op block documentation:

1. The surgeon's request is noted in the record.
2. The anesthesia team discussed the block with the patient.
3. There was consent process for the block.

The RVG updated its statement on transesophageal echocardiography (TEE) to include 3-D code **93355**. Share the highlights of the statement. It is performed on patients who:

- Are undergoing major transcatheter cardiac or vascular intervention.

- Have cardiovascular disease.
- May have severe co-morbidities that contraindicate open surgery.
- Are at risk for hemodynamic disturbances due to cardiovascular lesions.

**New notes can hone coding**

The 2016 RVG also added or revised coding statements to eight anesthesia codes. For example, use **00218** (Anesthesia for intracranial procedures; procedures in sitting position) to drive home the importance of documenting patient position. A new note for the code states it should be reported for any intracranial procedure performed on a patient in the sitting position. The service has a base unit value (BUV) of 13, so a failure to note the patient was in the seated position could be a costly mistake.

You'll find clarification on how to report cardiac cases and the level of documentation you need. Anesthesia for the insertion of a permanent transvenous pacemaker (**00530**) should be reported only when the procedure includes programming and testing of the lead and the generator.

For insertion or replacement of a pacing cardioverter-defibrillator (ICD/C), you may report **00534** when the surgeon performs the tests used for a transvenous pacemaker, plus active testing of the cardioversion or defibrillator functions. If the anesthesia note indicates the pacemaker test but not the ICD/C test, you would report 00530.

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PAS2016

Remind coding staff that services for transurethral cystoscopic procedures should be reported with codes **00910-00918**, according to new notes for **00860** (Extraperitoneal procedures of the urinary tract; not otherwise specified) and **00862** (...; renal procedures, including upper one-third of ureter, or donor nephrectomy).

Documentation for lithotripsy services is another potential trouble spot. The note for lithotripsy with water bath (**00872**) directs you to **00873** when the service is performed with small water filled drums or cushions.

## Share changes to the crosswalk

Each year, the ASA issues crosswalk guidance for new codes, revises primary and alternate crosswalk codes and updates comments. Here is an example of each kind of change listed in the Crosswalk's summary of additions and revisions:

**1. Revised crosswalk.** Image-guided fluid collection drainage by catheter (**10030**) now crosswalks to non-invasive imaging code **01922** (7 BUV), instead of interventional system code **00400** (3 BUV).

**2. Revised alternates.** Total disc arthroplasty of the cervical (**22856**) and lumbar (**22857**) now have an alternate code. Spinal surgery with instrumentation code **00670** is now listed.

**3. Crosswalk for new procedure codes.** New percutaneous biliary procedures (**47531-47541**) crosswalk to **00700** (Anesthesia for procedures on upper anterior abdominal wall; NOS).

**4. New or revised comment.** A new note for resection or excision codes **61600-61608** instructs coders to use the alternate crosswalk code **00216** for intracranial vascular procedures.

**5. Revised anesthesia status.** Typanostomy with a ventilating tube (**69433**) no longer has a crosswalk anesthesia code. It is now listed as anesthesia care not typically required. — *Julia Kyles, CPC* ([jkyles@decisionhealth.com](mailto:jkyles@decisionhealth.com))

## RESOURCES:

- ▶ 2016 Relative value guide
- ▶ 2016 Crosswalk
- ▶ ASA standards and guidelines — online



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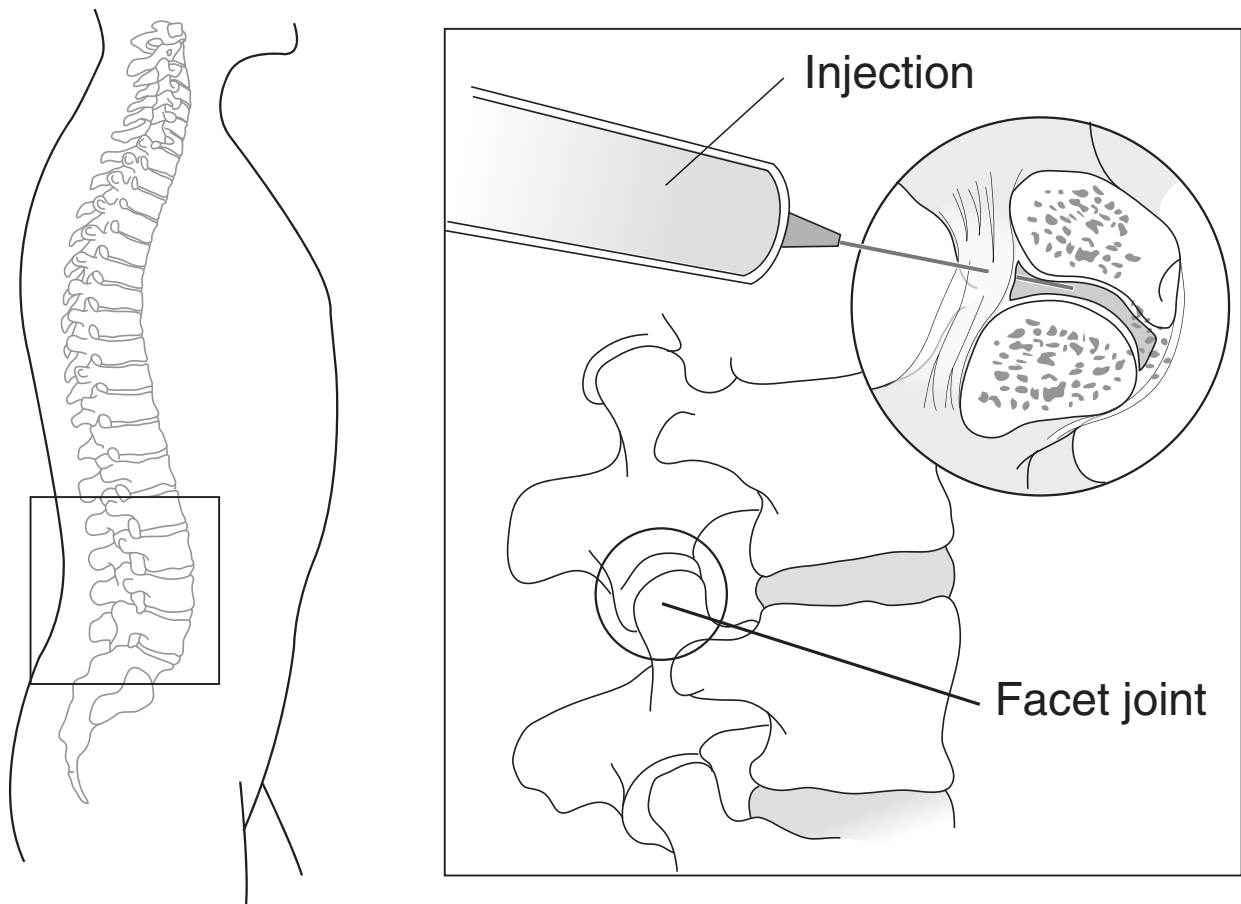
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## Lumbar facet joint blocks illustrated

Use this illustration to help staff visualize facet joint blocks and clear up confusion about counting levels for facet blocks. Remember, you count levels based on the joint, not the nerves, injected.

## Injection, diagnostic or therapeutic agent, paravertebral facet joint, lumbar or sacral



Single lumbar or sacral facet joint injection (64493); second level (64494); third and any additional levels (64495)

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