ANESTHESIA & PAIN
A Closer Look

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Agenda

• Identify key areas for maximizing revenue
• Proper documentation to support services billed
• Key changes in 2011
• Resources
Let’s Review

• Base units + time units

• Bundled services

• Dialogue in the OR
Invasive Lines

• Arterial Line (36620)
  – size, location, performing provider
  – in-situ

• Swan-Ganz (93503)
  – access to central circulation is bundled

• CVP (36555 or 36556)
Ultrasound

• Ultrasound guidance for needle placement (76942)
  • permanent images
  • description of localization process

• Ultrasound guidance for vascular access (76937)
  • u/s evaluation of potential access sites
  • selected vessel patency
  • concurrent real time u/s visualization of vascular needle entry
  • permanent recording and reporting
Maximize Revenue

• Determine surgical CPTs for all procedures performed during a single case

• Choose the surgical CPT that crosswalks to the highest valued ASA code

• Always use a crosswalking tool
Maximize Revenue

- Surgical vs. diagnostic arthroscopy
  - shoulder, elbow, and knee
- Surgical thoracotommy and thoracoscopy
  - one lung ventilation
- Diagnostic thoracoscopy and mediastinoscopy
  - one lung ventilation
- Bone procedures
  - particularly long bones
  - proximal, distal, and shaft
  - iliac crest bone graft
Maximize Revenue

• Breast mass excision
  • sentinel node biopsy/excision?

• Cystoureteroscopy (52352 – 52355)
  • location of stone, lesion, or tumor is critical as ASA code selection is determined by the location
  • an additional 2-4 units are warranted when location involves the upper 1/3 of ureter, kidney, or renal pelvis
Maximize Revenue

• Extensive spine procedures (00670)
  – spinal instrumentation
  – multiple vertebral levels
  – add-on code indicating multiple level procedure

• Colectomy – open partial and laparoscopic
  – alternate ASA 00840 applies when surgery is confined to sigmoid and/or rectum
Maximize Revenue

CARDIAC ANESTHESIA

• CABG with CPB (00567 – 18 base units)

• CABG without CPB (00566 – 25 base units)

• Non-coronary bypass px’s (valves) or re-operation for CABG more than one month after original operation (00562 – 20 base units)

• Heart, pericardial sac and great vessels of chest
  • with DHCA (00563 – 25 base units)
  • younger than one year of age (00561 - 25 base units)
Pitfalls

• Coding +99116 and +99135 in conjunction with cardiac anesthesia cases

• Coding +99100 in conjunction with age specific ASA codes (00326, 00561, 00834, 00836)

• U/S guidance – no image is stored

• Anesthesia provider documents “planned procedure” on anesthesia record
Pitfalls

Time Issues

- Rounding time
- Providers use both military and civilian time
- Split case including cosmetic service (private pay) and insurance covered procedure
- Including pre-anesthesia evaluation time in billable time
- Including invasive line and acute pain nerve block placement time in billable anesthesia time when performed prior to induction
- PACU In Time same as Anesthesia End Time
Pitfalls

• Attesting to medical direction criteria at the beginning of a case

• MAC vs. general anesthesia unclear

• CMS teaching physician documentation requirements not met

• Anesthesia providers personally performing very short cases (i.e., cardioversion, ECT) while medically directing
Pitfalls

• Coding +99140 for routine labor epidurals

• Anesthesia providers indicating +99140 for cases not meeting the emergency definition

• Coding from a charge ticket instead of the actual medical record

• Insufficient documentation to support second anesthesia provider
Pitfalls

• Coding from light carbon copies

• Unclear relief time documentation

• Acute pain blocks billed (with modifier 59) without documentation to support its purpose for postoperative pain management and no documentation to support the surgeon’s request for the service

• Daily hospital management of epidural/subarachnoid continuous drug administration (01996) billed same day as epidural placement

• Unbundling
Resources

• CMS Anesthesiologists Center
  • http://www.cms.gov/center/anesth.asp
    • Medicare Claims Processing Manual, Chapter 12 – Section 50
    • NCCI edits
      • NCCI Policy Manual for Physician Services (Chapter 2 – Anesthesia Services)

• American Society of Anesthesiologists
  • http://www.asahq.org/
Resources

• Medicare Administrative Contractor and Medicare Part B Carrier LCDs
  • Monitored Anesthesia Care
  • Transesophageal Echocardiography
  • Acute Pain Blocks
  • Cardiac Catheterizations
Resources
Recovery Audit Contractors

http://www.cms.gov/RAC/

• Region A – Diversified Collection Services, Inc.
  • [www.dcsrac.com](http://www.dcsrac.com)
  • CT, DE, DC, ME, MD, MA, NH, NJ, NY, PA, RI, VT

• Region B – CGI Technologies and Solutions, Inc.
  • [www.racb.cgi.com](http://www.racb.cgi.com)
  • IL, IN, KY, MI, MN, OH, WI

• Region C – Connolly Consulting Associates, Inc.
  • [www.connollyhealthcare.com/RAC](http://www.connollyhealthcare.com/RAC)
  • AL, AR, CO, FL, GA, LA, MS, NM, NC, OK, SC, TN, TX, VA, WV

• Region D – HealthData Insights, Inc.
  • [www.racinfo.healthdatainsights.com](http://www.racinfo.healthdatainsights.com)
  • AK, AZ, CA, HI, IA, ID, KS, MO, MT, NE, NV, ND, OR, SD, UT, WA, WY
Anesthesia – 2011 Update

• New ASA codes = 0

• Deleted ASA codes = 0

• Base Unit Value Changes = 0
Did You Know?

CMS has different base unit values for 10 ASA codes.


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<th>ASA Code</th>
<th>CMS Base Unit Value</th>
<th>ASA Base Unit Value</th>
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PQRI

PQRS – Physician Quality Reporting “System”

• Incentive = 1.0% of MPFS allowed charges
  • Successfully report on at least 50% of Medicare Part B fee-for-service patients receiving services to which the measure(s) apply
  • 2012 – 2014: 0.5% incentive
  • 2015 – Penalties begin for unsuccessful reporting

• Reporting period for claims based reporting:
  • January 1 – December 31, 2011
  • July 1 – December 31, 2011
Anesthesia – 2011 Update

PQRI

- Anesthesia Relevant Measures
  - Measure 30: Perioperative Care: Timely Administration of Prophylactic Parenteral Antibiotics
  - Measure 193: Perioperative Temperature Management
Anesthesia – 2011 Update
PQRI

• Two Clusters Available
  – Cluster #30: Anesthesia Care 1
    • Measure 30
    • Measure 76
  – Cluster #31: Anesthesia Care 2
    • Measure 76
    • Measure 193
2011 Crosswalk Changes

- “Anesthesia Care Not Typically Required”
  - Common chronic pain procedures
    - trigger point, joint, interlaminar epidural, and facet injections
- 11970 – tissue expander replacement with permanent prosthesis (00402 added)
- 33234 & 33235 – removal of transvenous pacemaker electrode(s) single & dual lead systems (new crosswalk 00520)
- 50230 – radical nephrectomy, including partial ureterectomy, any open approach including rib resection with regional lymphadenectomy and/or vena caval thrombectomy (00862 added)
- 63650 – percutaneous implantation of neurostimulator electrode array, epidural (new crosswalk 01936)
Chronic Pain – 2011 Update

Fluoroscopic or CT Guidance

- 64479 – Transforaminal epidural injection; cervical or thoracic, single level
  +64480 – ea. add level

- 64483 – Transforaminal epidural injection; lumbar or sacral, single level
  +64484 – ea. add level

Ultrasound Guidance

- 0228T – Transforaminal epidural injection; cervical or thoracic, single level
  +0229T – ea. add level

- 0230T – Transforaminal epidural injection; lumbar or sacral, single level
  +0231T – ea. add level
Paravertebral Facet Joints

Fluoroscopic or CT Guidance

• 64490 – Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic, single level
  +64491 – second level
  +64492 – third and any additional level

• 64493 – …lumbar or sacral; single level
  +64494 – second level
  +64495 – third and any additional level

Ultrasound Guidance

• 0213T – Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; single level
  +0214T – second level
  +0215T – third and any additional level

• 0216T – …lumbar or sacral; single level
  +0217T – second level
  +0218T – third and any additional level
Paravertebral Facet Injections

- Refers to injection directly into the facet joint or anesthetizing the medial branch nerves that innervate each joint

- Pay close attention to CPT parentheticals
  - If imaging not used, report 20552 – 20553
  - For bilateral injection procedure, use modifier 50
  - T12-L1 joint injection or nerves innervating that joint, use 64490
Paravertebral Facet Injection Examples

• Intra-articular injection of right L2-L3, and L3-L4 facet joints would be coded as (2 needle punctures):
  • 64493-RT
  • +64494-RT

• Injection of the right L1, L2, and L3 medial branch nerves that innervate the L2-L3 and L3-L4 facet joint levels is coded as (3 needle punctures):
  • 64493-RT
  • +64494-RT
Paravertebral Facet Injection

Examples

• Intra-articular bilateral injection of C2-C3, C3-C4, C4-C5, and C5-C6 facet joints would be coded as:
  • 64490-50
  • +64491-50
  • +64492-50

• Injection of the bilateral C2, C3, and C4 medial branch nerves that innervate the C2-C3 and C3-C4 facet joints would be coded as:
  • 64490-50
  • +64491-50
Paravertebral Facet Injection Examples

- Be Careful: while each facet joint receives dual innervation from two medial branch nerves, the L5-S1 level receives innervation from 3 nerves (L4 medial branch, L5 dorsal ramus, and S1). Therefore, a physician performing a right medial branch nerve block of L4, L5, and S1 nerves would only be coded as:
  - 64493-RT

Note: When coding destruction by neurolytic agent (i.e., radiofrequency lesioning) of paravertebral facet joint nerve (64622 – +64627), each nerve destroyed may be coded. In addition, radiological guidance is NOT included, and may be billed separately.
E-Prescribing (eRx)

• Could impact chronic pain practices
• Determine if your practice could be affected:
  • Are you an eligible professional?
  • Will your physician’s Medicare Part B Physician Fee Schedule charges for the codes specified in this measure’s denominator make up at least 10% of his or her total MPFS allowed charges in 2011?
  • Will the individual provider report a minimum of 100 encounters comprised of one of the denominator codes between 1/1/11-6/30/11?

• Denominators:  90801, 90802, 90805, 90806, 90807, 90808, 90809, 90862, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0109

• [http://www.cms.gov/ERxIncentive/](http://www.cms.gov/ERxIncentive/)
Thank You

QUESTIONS?