Beware of Reporting These New Procedure Codes With Anesthesia

New edits reach across the anesthesia spectrum.

Anesthesia providers are being hard-hit with CCI edits in the first quarter of 2016, with more than 2,700 new edit pairs going into effect for the specialty on Jan. 1.

**Simple strategy:** Adjusting to the edits won’t be difficult since they pertain to virtually every anesthesia code. Once you get familiar with the Column 2 codes, know you shouldn’t be reporting them with most anesthesia services (though double check before automatically skipping them since they might be allowed in a few situations).

Each code listed in these edits as a Column 2 component of anesthesia services is new for 2016. They are:

- 31652 – Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (e.g., aspiration[s]/biopsy[ies]), one or two mediastinal and/or hilar lymph node stations or structures
- 31653 – ... with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (e.g., aspiration[s]/biopsy[ies]), 3 or more mediastinal and/or hilar lymph node stations or structures
- 92537 – Caloric vestibular test with recording, bilateral; bithermal (i.e., one warm and one cool irrigation in each ear for a total of four irrigations)
- 92538 – ... monothermal (i.e., one irrigation in each ear for a total of two irrigations)
- 93050 – Arterial pressure waveform analysis for assessment of central arterial pressures, includes obtaining waveform(s), digitization and application of nonlinear mathematical transformations to determine central arterial pressures and augmentation index, with interpretation and report, upper extremity artery, non-invasive
- 99415 – Prolonged clinical staff service (the service beyond the typical service time) during an evaluation and management service in the office or outpatient setting, direct patient contact with physician supervision; first hour (List separately in addition to code for outpatient Evaluation and Management service)
- 99416 – ... each additional 30 minutes (List separately in addition to code for prolonged service)
- 99497 – Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate.
Two additional codes are included in edits with some anesthesia services:

- 64461 – Paravertebral block (PVB) (paraspinal block), thoracic; single injection site (includes imaging guidance, when performed)
- 64463 – ... continuous infusion by catheter (includes imaging guidance, when performed).

The rationale for all edits is “Standard preparation/monitoring services for anesthesia.” However, the designation with either modifier “0” or “1” is about 50/50.

**Remember:** A modifier indicator of “0” indicates that an edit can never be bypassed even if a modifier is used. In other words, the Column 2 code of the edit will be denied. A modifier indicator of “1” indicates that an edit may be bypassed with an appropriate modifier appended to the Column 2 code. If the pair that applies to your situation has a “1” modifier indicator, you might be able to report – and be paid for – both procedures with sufficient documentation.

**Example:** Each edit pair with 31652 or 31653 carries modifier 1, so separate reporting might be allowed. Each edit pair with 99145 or 99146 for prolonged clinical staff services carries modifier 0 so you should report only the anesthesia code.

**Good news:** The edits still do not bundle invasive monitoring lines (such as CVP, arterial, or Swan-Ganz lines) with the newly announced pairs, points out **Kelly D. Dennis, MBA, ACS-AN, CANPC, CHCA, CPC, CPC-I**, owner of **Perfect Office Solutions in Leesburg, Fla.** This is good news for anesthesiologists because you can continue to report those line placement services separately.

**Deletions:** CCI updates will occasionally include deletions that reverse previous edits and allow you to submit code pairs that had been banned. The January CCI file does list thousands of deleted edits, but don’t get your hopes up for new reimbursement. Each pair includes a code that is no longer valid as of Jan. 1, 2016, such as 64412 (Injection, anesthetic agent; spinal accessory nerve).

**Billing**

**Start the New Year With the Right Collections Perspective**

**Tip:** Double check every detail of your patients’ information.

You might have moved into the New Year with goals for improving things in your personal life, but have you set new goals for improving your practice’s...
Knowing that a patient has hypertension is an important fact for anesthesia providers to take into consideration as they map out and implement the anesthesia plan. When coding for cardiac cases, pay special attention to diagnoses such as primary pulmonary hypertension and how you’ll report it under ICD-10.

Starting point: The one-to-one crosswalk from ICD-9 to ICD-10 keeps primary pulmonary hypertension coding fairly simple. Previous ICD-9 code 416.0 (Primary pulmonary hypertension) has an identical descriptor in ICD-10 with I27.0 (Primary pulmonary hypertension).

Get Details From Surgeon to Confirm Primary Pulmonary Hypertension

Heads up: Pay attention to the new Excludes1 note.

bottom line in 2016? If not, it’s time to think of some basic strategies that can help your collection procedures.

Here’s why: Even simple lapses in recording patient information such as spelling a name wrong, confusing the secondary payer with the primary and even incorrect insurance ID number can cause your claims to be denied. Manny Oliverez, CPC, CEO of Capture Billing and Consulting, Inc., in South Riding, VA, shares his experiences handling medical practices’ billings — and they can help ensure you maximize your income potential in 2016.

Verify All Patient Information

You may think that you need to invest in an expensive accounts receivable (A/R) software program or hire pricey consultants to increase your A/R, but there’s one tip that can help you collect more income without costing you a dime, Oliverez says.

“One of the biggest problems I see in some of the medical practices we start to work with is that incorrect patient information was entered into the computer system,” he says. “Misspelled patient names, wrong dates of birth, typos in the insurance ID number, and secondary insurance put in as primary all lead to the claims being denied. This causes the accounts receivable to skyrocket and spiral out of control.”

Not only does this issue create denials, it can sometimes have an impact far beyond that one patient encounter. “Often the problem gets so overwhelming the denials are hardly worked at all, leaving thousands, if not tens of thousands of dollars, on the table,” Oliverez says. “Take care of this one problem and income is sure to rise.”

Don’t Shy Away From Billing Patients

Another area where practices can quickly and inexpensively make an impact involves approaching patients for their portion of the balance. Oliverez sees dozens of practices that don’t have a quality patient collection process, which has become more important than ever as deductibles rise.

“I’ve come across practices that haven’t billed patients in months — one had actually never billed any patients at all,” he says. “The front desk should have procedures in place to collect all copays and balances at the time of service. The billing department needs policies on when and how many patient statements to send, when to mail out demand letters, how many phone calls to make and (if appropriate) when to send an account to collections. And it all needs to be done consistently.”

For example: The 2016 Part B deductible is $166.00. Suppose you fail to collect the deductible for just two patients a day. In January alone, this will cost you $6,640, assuming your practice is only open on the weekdays.

Takeaway: Since most practices can’t afford to simply write off almost $7,000 a month, now is the time to establish a process of billing patients on the day of the visit, as well as one to ensure you send them bills for any balances afterward.
ICD-9 coding rules: Code 416.0 applied to “Idiopathic pulmonary arteriosclerosis” and “Pulmonary hypertension (essential) (idiopathic) (primary),” according to a list with the code. It excluded pulmonary hypertension NOS and secondary pulmonary hypertension, which you reported with 416.8 (Other chronic pulmonary heart diseases).

ICD-10 changes: ICD-10 indexes “Arteriosclerosis, pulmonary (idiopathic)” to I27.0. Similarly, the index points to I27.0 for the entry “Hypertension, pulmonary, primary (idiopathic).”

The surprise comes with code I27.0’s Excludes1 note listing pulmonary hypertension NOS and secondary pulmonary hypertension. Note that you should report both secondary and NOS diagnoses using the secondary code I27.2 (Other secondary pulmonary hypertension).

Documentation: The cardiologist in charge of the case should document primary or idiopathic to help support the choice of I27.0. Your provider needs to verify the specific type of hypertension so your claim will be consistent with the surgeon’s.

Coder tips: “Other” code 416.8 crosses to both I27.89 (Other specified pulmonary heart diseases) and secondary hypertension code I27.2. If you report I27.2, you also should code the underlying condition.

Condition details: Pulmonary hypertension is high blood pressure affecting arteries in the lungs. The condition also affects the heart, which eventually weakens and fails as the right ventricle works harder to pump blood through the lungs.

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Tell us what you think about Anesthesia Coding Alert.

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Please email Leigh DeLozier at leighd@codinginstitute.us

Thank you in advance for your input!

Reader Questions

Select 01991 for the Supine Position

Question:
If the anesthesiologist is providing anesthesia via TIVA or MAC for joint injections (knee, hip or SI), the descriptor reads “nerve blocks and injections.” What code should we use?

Oklahoma Subscriber

Answer:
The correct anesthesia code for these procedures normally would be 01991 (Anesthesia for diagnostic or therapeutic nerve blocks and injections [when block or injection is performed by a different physician or other qualified health care professional]; other than the prone position); the patient should be in a supine position for such injections.

Note: For the prone position, submit 01992 (... prone position) instead.

Additional info: Also use 01991 or 01992 to report anesthesia services in conjunction with an epidural, when administered. The ASA Crosswalk states “anesthesia care usually not required” for epidurals, but it sometimes is necessary. Be sure to have a documented medical reason for the anesthesia.

Learn to Calculate TBSA

Question:
What are our coding options for a second and third degree burn excision?

New Jersey Subscriber

Answer:
Coding for anesthesia during burn excision or debridement differs from other situations because you don’t simply choose a code based on the anatomic location. Instead, you focus on the extent of burn injury (or total body surface area, TBSA), which means you might need to brush up on some math skills.

CPT® provides three anesthesia codes for burn excision/debridement that differ from the anesthesia codes you’re used to seeing on a day-to-day basis:
» 01951 – Anesthesia for second- and third-degree burn excision or debridement with or without skin grafting, any site, for total body surface area (TBSA) treated during anesthesia and surgery; less than 4% total body surface area between 4 percent and 9 percent of total body surface area

» 01952 – ... between 4% and 9% of total body surface area

» +01953 – ... each additional 9% total body surface area or part thereof (List separately in addition to code for primary procedure).

**Warning:** Because +01953 is an add-on code, payers will not reimburse you if you report it without the appropriate primary code: 01952.

**Here’s how to calculate:** The attending physician should document the TBSA of the burn victim, often in collaboration with your anesthesiologist. The physicians need to agree on the amount of affected area so their claims will be consistent. For example, the anesthesiologist shouldn’t bill for an 18 percent body burn when the surgeon claims a 32 percent body burn. CPT® and ICD-10 both include information on “The Rule of Nines,” or the system physicians use to determine the extent of burn wounds. The CPT® illustration appears with burn treatment codes 16000-16030.

Look to 00561 for Your Youngest Pump Oxygenator Patients

**Question:** Our anesthesiologist used a pump oxygenator to accomplish hypothermia and rewarming following a CABG procedure on a 6-month-old patient. How should we report this?

**Tennessee Subscriber**

**Answer:** Because of the patient’s age, you should report 00561 (Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator, younger than 1 year of age). For an older patient in the same situation, you would submit 00562 (Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator; age 1 year or older, for all non-coronary bypass procedures [e.g., valve procedures] or for re-operation for coronary bypass more than 1 month after original operation).

**Heads up:** Hypothermia is bundled with CABG codes 00561-00566. That means you will not include 99116 (Anesthesia complicated by utilization of total body hypothermia [List separately in addition to code for primary anesthesia procedure]) on your claim.

**Report 00470 for Sternal Wire Removal**

**Question:** We provided anesthesia during the exploration of a sterna incision with removal of the lower sternal Talon and sternal wire. The postoperative diagnosis was “chronic draining sinus from prior internal plating of the sternum.” Is 00550 the best anesthesia code for the procedure?

**Mississippi Subscriber**

**Answer:** A better choice than 00550 (Anesthesia for sternal debridement) might be 00470 (Anesthesia for partial rib resection; not otherwise specified).

The procedure you describe was for sternal wire removal rather than debridement, which leads you away from 00550. The ASA Relative Value Guide lists 00470 as appropriate during sternal wire removal. Code 00470 carries a base value of 6.

**Bolster Documentation Before Reporting Anesthesia for 62304**

**Question:** What is the correct anesthesia code to report for 62304?

**Indiana Subscriber**

**Answer:** Anesthesia is not typically required for 62304 (Myelography via lumbar injection, including radiological supervision and interpretation; lumbosacral), which means the ASA Crosswalk does...
not include a code suggestion. An appropriate choice might be 01935 (Anesthesia for percutaneous image guided procedures on the spine and spinal cord; diagnostic), which is worth five base units. Verify that you have clear documentation of why separate anesthesia was medically necessary, and include that with the claim. ☐

Yes, You Can Translate Your Own Handwriting for MAC Review

**Question:**
One of my physicians has handwriting so terrible that I’m afraid of what might happen if his files are ever pulled for review. Is there anything we can do about this?

**North Carolina Subscriber**

**Answer:**
When Medicare payers come calling for your documentation to support claims, you may be faced with a dilemma — submit illegible records that the MAC may not be able to read, or send nothing and expect to have to pay back all the money you collected for the services. Fortunately, one Part B MAC has a third option.

“If a provider feels that his/her notes may not be legible, he/she may translate these notes prior to submitting them to Palmetto GBA for review,” the MAC said in a Nov. 25, 2015, tip on its website. “The note must be translated verbatim and signed by the provider.” You must then submit both sets of notes — the illegible and the translated version — to the payer for review. ☐

Brush Up on Your Locum Tenens Criteria

**Question:**
One of our physicians will be taking a six-month sabbatical, so we need to hire a locum tenens to substitute for her. Could you share some tips on how to find a good substitute physician?

**Michigan Subscriber**

**Answer:**
When one of your physicians takes extended leave, you can hire a locum tenens physician to take the absent physician’s place. You might also hire a locum to fill in for physician assistants (PAs), nurse practitioners (NPs), or certain other providers (although remember that Medicare will not allow a PA or NP to function as locum tenens providers or pay for a locum tenens replacement for those non-physician practitioners).

There are a number of companies that can help you connect to a locum provider in your area. A simple website search will turn up several links that can take you to staffing specialists who could give you leads on local locum physicians. The challenge, however, is finding a provider that matches your practice’s needs.

When you are searching for a locum provider, you typically won’t have much direct contact with the person you actually end up hiring; you’ll deal mostly with the staffing agency that handles the locum’s assignments, so choose the staffing agency carefully.

When you contact the staffing agency, be sure you have some basic information ready, such as:

- What type of provider you need;
- Which specialty you need a locum for;
- The exact time frame you’ll employ the locum; and
- The compensation you’ll offer for the locum (this doesn’t have to be an exact amount; a pay range is acceptable).

You’ll also want to be sure to lay out expectations for the locum provider when you deal with the staffing agency, so there aren’t any surprises when the locum reports for work.

**Example:** Check out this partial job description from an online ad for a locum physician:

“The physician is expected to:

- practice in accordance within accepted professional standards, organizational values, and with a commitment to excellent customer service;
- demonstrate respect for patients and family while administering care;
- maintain confidentiality of patient information; and
- meet or exceed all current applicable standards of the Joint Commission Accreditation of Health Care Organization.”

Once the locum arrives, be sure to include modifier Q6 (Service furnished by a locum tenens physician) on his or her claims. Remember that Medicare guidelines only allow a locum tenens physician to fill in for up to 60 consecutive calendar days. After that point you need to have another locum tenens take over. ☐
Cervical Plexus Block Can Warrant a Separate Code

Question:
The anesthesiologist administered a cervical plexus block following a carotid endarterectomy, but it was not for postoperative pain management. Can I code it separately?

Answer:
You should only report the cervical plexus block separately when the surgeon requests it for post-op pain management and the procedure is documented as such. In those situations, report 64413 (Injection, anesthetic agent; cervical plexus) and append modifier 59 (Distinct procedural service) to indicate that it is separate from the surgical procedure.

You Be the Coder

Know When and How to Use P Modifiers

(Question on page 13)

Answer:
There is always the risk of adverse reaction when a patient needs anesthesia. The P (physical status) modifiers indicate the patient’s physical status pre-anesthesia, which paints a better picture of the overall encounter. Your choices are as follows:

» Modifiers P1 (A normal healthy patient) and P2 (A patient with mild systemic disease) indicate minimal to no risk to the patient during the surgery. Generally, most people under the age of 30 will fall into this category.

» Modifiers P3 (A patient with severe systemic disease) and P4 (A patient with severe systemic disease that is a constant threat to life) indicate a moderate to constant threat to a patient’s life when undergoing surgery.

» Modifier P5 (A moribund patient who is not expected to survive without the operation) is for patients who are pretty sickly. The surgery could life saving or life threatening, but without the surgery, the patient will surely die.

» Modifier P6 (A declared brain-dead patient whose organs are being removed for donor purposes) indicates a patient who is brain dead but the body is still alive. You’ll typically use P6 for a patient who is receiving anesthesia to harvest organs before the provider removes life support.

Though some payers — including traditional Medicare — will not pay anything extra for P modifiers, payers might require the modifiers to prove medical necessity for other anesthesia services in certain situations. The patient’s physical status must be documented in the patient’s medical record, regardless of whether you’ll be reimbursed for it. If you are not sure whether the modifier is paid separately, you should include the appropriate P modifier on the claim.
Anesthesia Coding Alert

We would love to hear from you. Please send your comments, questions, tips, cases, and suggestions for articles related to Anesthesia Coding Alert to the Editor indicated below.

Mary Compton, PhD, CPC
maryc@codinginstitute.us
Editorial Director and Publisher

Jennifer Godreau, CPC, CPMA, CPEDC
jenniferg@codinginstitute.com
Director of Development & Operations

The Coding Institute LLC, 2222 Sedwick Road, Durham, NC 27713

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