Follow Our Foolproof Ways to Stop Hypothermia Coding Errors Cold

➤ 3 criteria signal +99116 is OK.

Before you can capture qualifying circumstances pay for hypothermia, pay attention to certain documentation details and requirements. Checking the details in your provider’s notes and paying close attention to the applicable anesthesia code can help you ward off any fears of incorrect reporting.

To find the code for hypothermia, you’ll need to flip to the back of your CPT book to “Qualifying Circumstances for Anesthesia.” The code you’ll focus on is +99116 (Anesthesia complicated by utilization of total body hypothermia [List separately in addition to code for primary anesthesia procedure]).

1. Ensure Hypothermia Is Induced

Dissecting the hypothermia code descriptor tells you two important things about correctly reporting +99116:

- The term “utilization” lets you know that the patient’s hypothermic state was induced (that is, on purpose), not incidental.
- Because it’s an add-on code (designated by the “+” sign), you know you can report it only in conjunction with a comprehensive anesthesia code. That doesn’t mean it applies each time a chart mentions hypothermia, however.

2. Bill +99116 When Hypothermia’s Not Inherent

“There are certain anesthesia codes which include hypothermia,” Samantha Mullins, CPC, PMCC, MCS-P, ACS-AN, director of compliance with Medac Anesthesiology Billing Associates in Birmingham, Ala., taught in the national conference session “Qualifying Circumstances Coding, Physical Status, and Billing for Other Medical Services” for The Coding Institute. “Therefore, it’s invalid to append +99116,” she says.

Simple to see: Hypothermia inclusion is obvious with some codes, such as 00561 (Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator, younger than 1 year of age). The code’s descriptor doesn’t spell it out, but the associated note does: “Do not report 00561 in conjunction with 99100, 99116, and 99135.”

“Coders must remember that for most heart cases, hypothermia is already included in the base of the anesthesia code,” explains Judy A. Wilson, CPC, CPC-H, CPC-P,
CPC-I, CANPC, CMBSI, CMRS, business administrator for Anesthesia Specialists, PTR, in Virginia Beach.

Harder to catch: Other anesthesia codes also include hypothermia, though it’s less clear. Check out these examples:

- You can’t report +99116 with 00562 (... 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); the key term is “with pump oxygenator,” because of the service it represents. Explanation: When your anesthesiologist uses a pump oxygenator during cardiac surgery, no blood circulates through the coronary arteries; therefore, the myocardium (or heart muscle) is ischemic (meaning there is restricted blood supply). Hypothermia is a routine part of the procedure to help protect the heart from ischemic injury.

- Also steer clear of reporting +99116 with 00563 (... with pump oxygenator with hypothermic circulatory arrest). The mention of a pump oxygenator sends you away from +99116, as does the hypothermic circulatory arrest. Your anesthesiologist induces hypothermic circulatory arrest to significantly slow cellular activity levels and stop blood circulation. Bringing the patient to that state allows the surgeon to safely complete procedures when he can’t use clamps to contain the blood flow. “This would take place during an aortic arch case as you cannot clamp off because the patient would surely have a stroke, for example,” Wilson says. “The temperature must be brought down to about 18 degrees Centigrade and the patient is in hypothermic circulatory arrest.”

Common, not a given: Your anesthesiologist will often induce hypothermia during intracranial surgeries to treat aneurysms, cerebral AV malformations, and other cerebrovascular procedures, but it’s not considered routine. In these cases, you can safely report +99116 in addition to the anesthesia code and garner your physician a well-deserved boost in pay.

3. Encourage Good Documentation

As with any claim, you can code based only on your physician’s documentation. Simply charting the patient’s temperatures or noting “warming” in his notes won’t justify the use of +99116.

Instead, teach your anesthesiologist to include phrases such as “hypothermic state induced,” “surgeon’s request for hypothermia initiated,” or “temp reduced to 34.5 degrees C per surgeon request.” Then you’ll have what you need to legitimately add +99116 to your claim when the corresponding anesthesia code allows.
News Flash: Check Usage of 50, Add-Ons for Facet Injections

▸ Thank the OIG for clarified guidelines from CMS.

CMS clarified its stance on correctly reporting modifier 50 (Bilateral procedure) and add-on codes for facet joint injection services with an effective date of Aug. 31, 2009 (CR Transmittal R526OTN). Here’s the quick version of what you need to know:

• If your physician performs facet joint injections on both sides of one level of the spine (such as right C4-C5 and left C4C5), you must append modifier 50 with the appropriate procedure code.

• If your physician performs facet joint injections on multiple levels on the same side of the spine (such as right C4-C5 and right C5-C6), submit the appropriate CPT add-on code to report the additional levels — not modifier 50.

When it’s time to report facet joint injections, you have four coding choices:

• 64470 — Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, single level
• +64472 — ... cervical or thoracic, each additional level (List separately in addition to code for primary procedure)
• 64475 — ... lumbar or sacral, single level
• +64476 — ... lumbar or sacral, each additional level (List separately in addition to code for primary procedure).

Remember 50 for Both Sides, Same Level

Use 64470 and 64475 for single injections to the cervical/thoracic or lumbar/sacral area. Add +64472 or +64476 for additional injections to the same side of the spine. When the procedure is bilateral, append modifier 50 to the corresponding facet joint injection code.

“The issue wouldn’t be too complex if there was only the single code for all levels, but the add-on code really seems to throw providers and coders for a loop,” says Marvel J. Hammer, RN, CPC, CCS-P, PCS, ACS-PM, CHCO, owner of MJH Consulting in Denver.

The transmittal clarifies that you must report modifier 50 when the right and left facet injections are administered at the same level.

“If you do a right facet injection you can’t do the left from the same injection,” explains Scott Groudine, MD, professor of anesthesiology at Albany Medical Center in New York. “You have to start over again, so the work is very similar to doing another level on the same side.”

Because the work is essentially the same (no difference for a different level versus the contralateral side), many physicians thought it appropriate to be paid for a new level.

Reimbursement watch: Multiple procedure discounts don’t apply to add-on codes, so you’ll be paid the full amount if your physician bills +64472 or +64476. If you append modifier 50 to indicate a bilateral procedure, however, expect a 50 percent reduction in allowable.

Learn more: The revision stemmed from an OIG medical record review of facet joint injection services that showed physicians incorrectly billed additional add-on codes to represent bilateral injections, with some specialties having an error rate up to 97 percent. The data studied was from procedures performed in 2006. The complete OIG report is viewable at www.oig.hhs.gov/oei/reports/oei-05-07-00200.pdf.

Stimulate Your Pay With 2 SCS Coding Tips

▸ Pair codes, count electrodes to jump-start your way to a healthier bottom line.

Whether you’re coding for a neurostimulator trial or permanent placement, keeping two factors in mind can streamline your reporting:

• Remember all your codes to ensure you report the correct stimulator
• Teach your physicians the difference documentation can make to the bottom line when they give you more details.

Capture 2 Services Using These Codes

CPT’s codes for spinal neurostimulators (or SCS, spinal cord stimulators) apply to both simple and complex equipment. The system includes one or more implanted neurostimulator leads/arrays, extension wires, an implanted generator, an external programmer/controller, and possibly an external recharging system. Each

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neurostimulator lead has electrical contacts or electrodes (typically four to eight) to provide stimulation to the corresponding spinal nerves and/or individual peripheral nerves.

When reporting an SCS procedure, code for both the placement and insertion. Here’s how:

- **63650 (Percutaneous implantation of neurostimulator electrode array, epidural)** represents electrode placement and “is often performed in a trial to determine whether an implant will successfully manage the patient’s painful condition,” says Gregory Przybylski, MD, director of neurosurgery at the New Jersey Neuroscience Institute, JFK Medical Center in Edison. CPT includes another SCS placement code (63655, Laminectomy for implantation of neurostimulator electrodes, plate/paddle, epidural), but you’ll probably never report it. Your physician might work with a spine surgeon during a laminectomy approach, but a pain management physician would rarely — or never — solely perform 63655.

- **63685 (Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling)** for the incision and subcutaneous placement of the pulse generator or receiver.

**Count Leads for More Accurate Pay**

“Make sure your physician’s documentation is as specific as possible, especially when billing for the leads,” says Dawn Shanahan, CPC, supervisor of coding for Florida Gulf to Bay Anesthesiology Associates in Tampa. “How many leads, and how many contacts per lead? You don’t want to leave money on the table.”

**Real world example:** In Florida, Medicare allows $418.98 per electrode for placement in an office setting. If the lead has an 8-electrode array, your reimbursement would be $3,351.84; you’d be reimbursed $6,703.68 for a lead using a 16-electrode array.

“If you don’t know which type of electrode array (8 or 16) or how many lead arrays were actually placed, then how can you properly bill?” Shanahan points out.

Medicare might ask for a copy of the invoice for the leads and for clarification of how many leads your physician placed, Shanahan says. “If the operative notes aren’t clear, you could get a denial or reduced payment, which could cost you money since you have to pay for the equipment.”

Note: For more on documentation, medical necessity, and diagnosis requirements for a patient who’s scheduled for a neurostimulator implant procedure, see “Clue In to 3 Details for SCS Coding Success” in Anesthesia and Pain Management Coding Alert, Vol. 11, Number 10.

**Nerves Treated Dictate Wrist Block Code**

**Question:** Our physician administered several injections to several nerves in a patient’s wrist to treat chronic wrist pain due to an old injury. How do I report what he described as “median nerve injection”?

**Answer:** You basically have two codes to select between, based on the anatomic site and nerves injected:

- **64450 (Injection, anesthetic agent; other peripheral nerve or branch)** or **20526 (Injection, therapeutic [e.g., local anesthetic, corticosteroid], carpal tunnel).**

Here’s the difference between the two codes:

- In 64450, the physician injects a local anesthetic into the branch of the nerve being anesthetized for pain control or blockage. You use 64450 for nerve blocks of nerves that don’t have a specific CPT code listed in the section of somatic nerve injections.
- With 20526, the physician administers a single therapeutic injection of corticosteroid and/or anesthetic to...

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**Reader Questions**

**Check That You Report the Right Neurostimulator**

Different types of neurostimulators are available, but as a pain management coder, you’ll probably see peripheral nerve stimulators most often. If your provider inserts a cranial nerve stimulator, it’s typically to treat the trigeminal nerve (cranial nerve V) for conditions associated with trigeminal neuralgia (350.1), says Marvel J. Hammer, RN, CPC, CCS-P, PCS, ACS-PM, CHCO, owner of MJH Consulting in Denver.

Double check that the physician implants a dorsal column, permanently implanted stimulator before coding the procedure. There are other types of stimulation treatments, so be sure you’re not coding for one of the other therapies by mistake.
the wrist crease between the tendons of the radial flexor and the long palmar muscles of the forearm. The injection blocks the radial nerve as it passes through the carpal tunnel and helps provide temporary relief of carpal tunnel syndrome symptoms.

Precert, Notes Can Help With Multiple 64640

**Question:** We report 64640 for radiofrequency ablation (RFA) of the sacroiliac (SI) joint. When the physician treats the lateral branches of the S1-S4 nerves, we either submit 64640 x 4 units or list each 64640 on a separate line, depending on the payer. Medicare is denying the claims based on the daily frequency or units. How should we handle this?

**Answer:** The carrier might deny your claim because, although 64640 (Destruction by neurolytic agent; other peripheral nerve or branch) is the best code choice for radiofrequency ablation of the nerves providing sensory innervation to the posterior SI joint, billing it four times within a session might be considered unusual.

**Try this:** Indicate the individual nerves destroyed (such as “S1, S2, S3, and S4 lateral branches”) in Box 19 (or the electronic equivalent). If Medicare denies a claim you’ll need to go through the appeals process, including sending your physician’s documentation of the separate and distinct RFA of each of the four nerves. Also encourage your physician to include adequate documentation to support the medical necessity of the procedure.

Denial for G0260? Make the Move to 27096

**Question:** We report G0260 when we bill for sacroiliac (SI) injections our physician performs in an ASC setting. Why are our payers denying it?

**Answer:** G0260 (Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography) is a valid code, but not one that physicians should bill. You should report 27096 (Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid) instead.

Heads up: Many carriers have special coverage issues or medical necessity requirements for SI injections, so check your local payer’s guidelines before submitting your next claim.

Clarify Injection Type, Insertion Point for Epidural

**Question:** Our physician used X-ray under fluoroscopy to complete what he called an “epidural catheter placement” for a patient with three fractured ribs. How should I code this?

**Answer:** First, check the documentation to verify whether your physician placed an epidural catheter instead of administering a single epidural injection via a temporary catheter, because that difference will guide your coding. You’ll also need to know the specific anatomic insertion location because that's what your coding choices center on:

- 62310 — Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic
- 62311 — ... lumbar, sacral (caudal)
- 62318 — Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including

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Anesthetic, antispasmodic, opioid, steroid, other solution, epidural or subarachnoid; cervical or thoracic
• 62319 — ... lumbar, sacral (caudal).

**Bonus:** You can report fluoroscopic guidance for an epidural steroid injection (ESI) with 77003 (Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic therapeutic injection procedures [epidural, transforaminal epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve, or sacroiliac joint], including neurolytic agent destruction).

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**Anesthesia Fee Includes Retrobulbar Block**

**Question:** The surgeon sometimes asks our CRNA to perform an eye block and then provide anesthesia during a cataract procedure. Are both these services billable? 

South Dakota Subscriber

**Answer:** According to Correct Coding Initiative (CCI) edits, a retrobulbar block (67500, Retrobulbar injection; medication [separate procedure, does not include supply of medication]) is bundled into 00142 (Anesthesia for procedures on eye; lens surgery). Because of this, you’ll report only the anesthesia code.

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**EGD + Colonoscopy = 1 Anesthesia Code**

**Question:** How should I handle the claim when our physician provided only an overall start/end anesthesia time (60 minutes) for an EGD plus colonoscopy? Do I report both codes and split the time between them? 

Alaska Subscriber

**Answer:** CPT’s anesthesia guidelines for separate or multiple procedures indicate that you report the “most complex” procedure; this differs slightly from the American Society of Anesthesiologists’ recommendation to bill the “anesthesia code with the highest base unit value.” Both resources direct you to report the combined/total time with a single procedure.

Codes 00740 (Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum) and 00810 (Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum) have the same base value of 5. You can submit either code with the total start/stop times; just be sure to include both diagnosis codes.

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**Educate MDs About How AD Hits Bottom Line**

**Question:** We’ve never reported modifier AD, but recently had a situation where our anesthesiologist was supervising five CRNAs concurrently. How does this affect our reimbursement, and does reporting AD raise a red flag with Medicare? 

New York Subscriber

**Answer:** This situation comes along periodically, so it shouldn’t garner extra attention from your payers. According to Medicare guidelines, “Carriers may allow only three base units per procedure when the anesthesiologist is involved in furnishing more than four procedures concurrently or is performing other services while directing the concurrent procedures. An additional time unit may be recognized if the physician can document he or she was present at induction.”

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Translation: Medicare requires modifier AD (Medical supervision by a physician: more than 4 concurrent anesthesia procedures) when the situation merits it. If some of the cases involve other payers, try to find out if they accept modifier AD before submitting the claim.

Payment cut: Your anesthesiologist will not receive payment for his time, no matter how long he spends on each of the AD cases. To get paid for the additional “time unit” mentioned in the guidelines, you must confirm and report that the physician was present at induction and enter a note in box 19 of the paper claim (or your electronic equivalent for notes).

Track payments for each modifier AD claim and show your physicians how medical supervision cases impact revenue. Sometimes your anesthesiologist can’t avoid crossing into modifier AD territory; but if he sees how it affects the bottom line he might try harder to avoid being caught in those situations.

Verify Reason for OR Return Before Coding

Question: A patient returned to the operating room (OR) later the same day of surgery because of post-op bleeding after a small bowel resection with lysis of adhesions. The surgeon performed a splenectomy during the second session. The same anesthesiologist was present for both surgeries. What modifier and documentation should I include with the claim?

Answer: Submit 00790 (Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; not otherwise specified) and a diagnosis for the postoperative bleeding, such as 998.1x (Hemorrhage or hematoma or seroma complicating a procedure).

Coders vary in their advice on whether to include a modifier for the procedure:

• Modifier 59 (Distinct procedural service) identifies procedures that are not normally reported together but were performed on a different body site or during a different procedure or surgical session, required a separate incision, were related to separate injuries, or were performed during different sessions or encounters.

• Modifier 78 (Unplanned return to the operating/ procedure room by the same physician following initial procedure for a related procedure during the postoperative period) is often viewed as a surgical modifier, but some payers prefer its use. For example, Medica in Minnesota will reimburse separately for multiple anesthesia services provided on the same date of service for separate anesthesia encounters; the policy directs you to append modifier 78 to the code for the second anesthesia encounter.

Before you code: Talk through the case with your anesthesiologist to verify the details. Then check with the payer in question to determine whether modifier 59 or 78 is appropriate.

Tag 00740 and 00810 for Most Gastro Procedures

Question: Our physicians are planning to offer general and/or MAC anesthesia for colonoscopies and EGDs. What will be the correct codes for these services?

Answer: You’ll want to report 00740 (Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum) for the EGD and 00810 (Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum) for the colonoscopy.

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You Be the Coder

Choosing for Hybrid Maze

Answer: During a hybrid maze procedure, the surgeon goes through the diaphragm and does not open the chest, so your most appropriate anesthesia code would be 00537 (Anesthesia for cardiac electrophysiologic procedures including radiofrequency ablation).

The hybrid maze uses an advanced ablation system and catheter-based pulmonary vein isolation for patients who might need more aggressive treatment for atrial fibrillation or who have a previously failed ablation.

Caution: Some payers, such as Aetna, classify the hybrid maze procedure as experimental and investigational unless the patient meets certain criteria. Be sure to verify your carrier’s policy so you know whether to expect coverage.
Although EGDs and colonoscopies might be the most common procedures your anesthesiologists assist with, also be prepared with 00790 (Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; not otherwise specified) for gastric procedures or laparoscopic gallbladder procedures.

Central Line With SG Cath Depends on Placement

**Question:** Our anesthesiologist recently documented that we should code for a central line, arterial line, and Swan-Ganz catheter during a procedure. It’s been a long time since one of our physicians marked all three for a single case; what’s the current rule regarding line coding?

**Answer:** You can bill the arterial line with 36620 (Arterial catheterization or cannulation for sampling, monitoring, or transfusion [separate procedure]; percutaneous). The central line (36556, Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older) is included in the Swan-Ganz (93503, Insertion and placement of flow directed catheter e.g., Swan-Ganz for monitoring purposes) fee when your physician uses both, which means you won’t normally code for both.

**Exception:** You can report both lines if your anesthesiologist documents separate locations and placements for the central line and Swan-Ganz catheter. Otherwise, you’ll code with 36620 and 93530.

— Answers to You Be the Coder and Reader Questions were provided by Scott Groudine, MD, an Albany, N.Y., anesthesiologist; and Marvel J. Hammer, RN, CPC, CCS-P, ACS-PM, CHCO, owner of MJH Consulting in Denver.