2017 Coding and Reimbursement Survival Guide

Chapter 1: Anesthesia

Documentation: Include All These Details for Cancelled Anesthesia

Remember, timing is everything.

As an anesthesia coder, you know you have special considerations when filing a claim for a procedure that was canceled before its completion. Here’s exactly what your providers need to be documenting for reimbursement success.

Situation 1: Cancellation Between Evaluation and Induction

Sometimes a physician – either the surgeon or anesthesiologist – decides to cancel a procedure prior to anesthesia induction because of something related to the patient’s health status (such as high blood pressure) or other circumstances (such as equipment failure).

If the anesthesia provider has completed the preoperative evaluation but has not induced the patient, he might still get paid for his time. The way you handle this depends on the situation and the insurer’s guidelines.

- If the payer accepts consultation codes, you can report the service that way (99241 - 99245 for office/outpatient or 99251-99255 for inpatient). However, your best tactic is to check the payer guidelines and any state-specific guidelines to ensure you’re filing correctly. For example, Blue Cross/Blue Shield of Alabama allows an E/M code, but Harvard Pilgrim allows a consultation code.
- If the case will be attempted again in a week or less, your provider probably will complete a brief pre-op exam instead of another full evaluation. If so, the original full exam will count toward the anesthesia service and you won’t bill for both encounters.

Caution: In the past, you might have reported the cancellation with an E/M code and modifier 53 (Discontinued procedure) but that’s no longer correct. Current CPT® guidelines state that you don’t use modifier 53 “to report the elective cancellation of a procedure prior to a patient’s anesthesia induction and/or surgical preparation in the operating suite.”

Be sure your provider includes the following documentation when a case is cancelled before induction:

1. Reason for termination
2. Services actually performed
3. Time spent giving pre-op care.

Situation 2: Cancellation After Induction

Under certain circumstances, a physician may terminate a surgical or diagnostic procedure due to extenuating circumstances or a situation that threatens the well-being of the patient (meaning continuing the procedure would put the patient at risk). For example, the anesthesiologist might see that the patient’s blood pressure has changed enough to merit stopping the case.

The following documentation must be included when a case is cancelled after induction:

1. Reason for termination
2. Service actually performed
3. Time spent giving pre-op, operative and post-op care
4. CPT® code for the procedure.

You have two coding options in this scenario. Some payers allow you to report the actual code in these situations (based
on the planned procedure); others prefer 01999 (Unlisted anesthesia procedure). From an anesthesia standpoint, the preferable way is to report the actual anesthesia code since it has an associated base value. Code 01999 is reimbursed based on individual consideration but must be reported if required by the carrier.

**Tip:** Also attach a brief note to the claim that points out the percentage of the procedure that was finished and why the procedure had to be stopped. For example, a comment such as, “30% of the procedure was completed. It was terminated as the patient had cardiac arrest” gives the insurer a clear understanding of the situation.

**Reimbursement: News you can use on the EHR Incentive Program**

*Anesthesiologists can still qualify for some exemptions.*

The final rule on stage 3 of CMS’s Electronic Health Record Incentive Program and modifications to meaningful use (MU) was released in early October, and the news is good for anesthesia providers. Physicians designated as anesthesiologists (specialty 05) in the Medicare Provider Enrollment, Chain, and Ownership System (PECOS) six months before the first day of payment adjustments for the year have an automatic exemption and do not need to apply to avoid the penalty. The final rule explicitly affirms the availability of the PECOS specialty exception, subject to annual renewal.

**Refresher:** The American Recovery and Reinvestment Act of 2009 established the Electronic Health Record (EHR) Incentive Program. Separate Medicare and Medicaid programs provide for incentive payments to eligible professionals (EPs) who are meaningful users of certified EHR technology. The year in which EPs could earn a Medicare incentive payment was 2014; the Medicaid program provides for incentives through 2016. Starting on Jan. 1, 2015, EPs who do not demonstrate MU under either the Medicare EHR Incentive Program or the Medicaid EHR Incentive Program are subject to a payment “adjustment” or penalty—unless they fall into an exception category. The penalty for not demonstrating MU in 2015 was one percent (1%) of the EP’s fee schedule payments. It grew to two percent (2%) in 2016 and will be three percent (3%) in 2017 and 2018.

**Also of interest:** The rule also includes an exemption for hospital-based eligible professionals (those who provide 90 percent or more of their covered services in a hospital inpatient or emergency room setting). CMS determines this classification based on the place of service codes on claims submitted to Medicare (POS code 21 for Inpatient Hospital and POS code 23 for Emergency Room - Hospital).

Non-anesthesiologist physicians (such as pain specialists) who will not be able to demonstrate MU in 2015 may apply for a hardship exception under the “extreme and uncontrollable” circumstances category. Those circumstances would likely include the inability to satisfy the EHR Incentive Program conditions because the Final Rule was not released until after the start of the last 90-day reporting period, according to a FAQ published on Oct. 7. In the FAQ, CMS also stated that, “In the past, CMS has considered these applications seriously and, in fact, has approved over 85% of hardship exemptions.”

For those physicians who do not qualify for any of the exemptions, the Final Rule relaxes the MU requirements for Stage 2 as modified and Stage 3 in a number of respects. One area of interest to all providers is the establishment of a single set of objectives and measures that all EPs were required to attest in 2015 and 2016. This replaces the core and menu structure of Stage 1 and the earlier version of Stage 2. In addition, the number of required objectives has been reduced from 18 to 10, including one consolidated public health reporting objective.

**CPT® Update: 2017 Brings an Overhaul to Your Epidural Coding**

**Plus:** Don’t overlook the moderate sedation changes.

The American Medical Association (AMA) has released full descriptors and details for CPT® changes for 2017, and you’ll definitely be affected by some as an anesthesia coder. Read on for the news you need to know.

**Say Hello to More Options and Details for Epidurals**

You’ve spent years reporting your provider’s epidural injections and catheter placements with four reliable codes:

- 62310 -- *Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization*
when performed, epidural or subarachnoid; cervical or thoracic

- 62311 -- lumbar or sacral (caudal)
- 62318 -- Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic
- 62319 -- lumbar or sacral (caudal).

That all has changed on January 1, 2017, however, when CPT® deleted 62310-62319 and introduced eight new replacement codes.

**The similarities:**

The new codes are differentiated by anatomic site (cervical/thoracic and lumbar/sacral). They also represent either a single epidural injection or an indwelling catheter placement.

**The differences:**

The word “interlaminar” has been added to describe the epidural’s placement as either “interlaminar epidural or subarachnoid.” One important deletion is what led to the expansion of choices: the descriptor no longer includes the phrase “includes contrast for localization when performed.”

Each code will now specify whether the provider used imaging guidance. Your choices for single-shot epidurals will be:

- 62320 -- Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance
- 62321 -- with imaging guidance (i.e., fluoroscopy or CT)
- 62322 -- Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance
- 62323 -- with imaging guidance (i.e., fluoroscopy or CT).

The breakdown for continuous infusion or intermittent bolus will be:

- 62324 -- Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance
- 62325 -- with imaging guidance (i.e., fluoroscopy or CT)
- 62326 -- Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance
- 62327 -- with imaging guidance (i.e., fluoroscopy or CT).

It could be hard to get used to the new epidural codes because we’ve had the other ones for so many years. And, as we understand it, ‘image guidance’ includes ultrasound even though it is not listed in the ‘i.e.’

**Say Goodbye to Some Moderate Sedation Codes**

Your anesthesia providers might not have many situations that merit their reporting moderate sedation, but you should still be aware of the options. In a move similar to the one with epidurals, the AMA has deleted some familiar moderate sedation codes and replaced them with new options.

In a nutshell: Moderate sedation codes 99143, 99144, and 99145 are deleted effective Jan. 1, 2017. Here’s a refresher of what they represent:

- 99151 – Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status; initial 15
minutes of intraservice time, patient younger than 5 years of age

- 99152 – ... initial 15 minutes of intraservice time, patient age 5 years or older
- 99153 – ... each additional 15 minutes intraservice time (List separately in addition to code for primary service).

**New tactic:** To report moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, you have three new choices:

- 99143 – Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status; younger than 5 years of age, first 30 minutes intra-service time
- 99144 – ... age 5 years or older, first 30 minutes intra-service time
- +99145 – ... each additional 15 minutes intra-service time (List separately in addition to code for primary service).

As you can see, these descriptors are exactly the same as codes 99151-99153, with one exception: the addition of the phrase “other than those services described by codes 00100-01999.”

**Important note:** Previously, the halfway point for time was 16 minutes as defined by CPT®. With the time change, the halfway point for time is now 8 minutes, which will allow reporting of moderate sedation services for the procedures that didn’t take 16 minutes to perform.

There has long been confusion about whether or not anesthesiologists would ever use these moderate sedation codes. They could, but these codes are meant for when whoever is doing the surgical procedure is providing sedation for the procedure and there’s either a physician or a nurse or otherwise ‘trained observer’ who is monitoring the patient’s vitals and condition.

Expert shares this example of when an anesthesiologist might use these moderate sedation codes: if/when he/she is doing pain management services and also providing sedation. The key will be in the level of depth of sedation, which is what those who are administering this sedation should be watchful for. Coders won’t be able to determine this without documentation from the clinicians that should indicate the type of sedation (‘moderate’ a.k.a. ‘conscious sedation’ or deep sedation.’

**Coding Edits: Last Edits of 2016 Bring No Real Changes for Anesthesia**

Finish the year with no substantial shifts in reporting.

The latest version of Correct Coding Initiative (CCI) edits went into effect Oct. 1, 2016 with good news for anesthesia providers and coders: none of the updates should affect your end-of-year claims.

The update did not include any edit pairs with anesthesia codes 00100-01996, or with other codes anesthesiologists use on a regular basis such as 93503 (Insertion and placement of flow directed catheter [eg, Swan-Ganz] for monitoring purposes).

**Patient Care: Get Clear on How to Apply Telemedicine Definitions**

**Hint:** Start by separating phone from online services.

The term “telemedicine” can be a catch-all of sorts with different meanings to different people. Read on for the most important points you need to know about coding for telemedicine services provided by your physician or other qualified nonphysician practitioner.

**Specify the Type of Service**

How you report telemedicine service depends largely on the service actually provided.

**Option 1:** If you are referring to a phone call, most payers do not recognize codes 99441 (Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service
provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion) through 99443 (... 21-30 minutes of medical discussion).

Option 2: If you are referring to online medical evaluations, there are several payers that will recognize 99444 (Online evaluation and management service provided by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient or guardian, not originating from a related E/M service provided within the previous 7 days, using the Internet or similar electronic communications network). Check with each payer to see its stance on 99444.

Option 3: If you are referring to telemedicine visits where the patient is in a remote location and you’re conducting the visit with two-way video and audio communication, you’ll choose between G0425 (Telehealth consultation, emergency department or initial inpatient, typically 30 minutes communicating with the patient via telehealth) through G0427 (Telehealth consultation, emergency department or initial inpatient, typically 70 minutes or more communicating with the patient via telehealth) for Medicare payers and payers that follow Medicare.

Keep the Purpose in Mind

Medicare designed these codes specifically for patients unable to make it to the office because of distance. You’ll use these codes mostly for usually initial office visits, emergency room services, or initial inpatient visits.


Caveat: Practices are using telemedicine more commonly as technology advances — and many regulators are pushing for tighter telemedicine guidelines.

The American Medical Association (AMA) discussed the emergence of this technology and the new and innovative healthcare challenges that come from utilizing it, at its 2016 meeting in Chicago. The discourse centered on telemedicine and ethics with the proposition of guidelines to address this critical issue.

Telehealth and telemedicine are another stage in the ongoing evolution of new models for the delivery of care and patient-physician interactions. The new AMA ethical guidance notes that while new technologies and new models of care will continue to emerge, physicians’ fundamental ethical responsibilities do not change.


File G89.18 for Post-op Pain Management Care

Your first step is to verify that you have a written request from the surgeon asking your anesthesiologist to provide post-op pain management care. Once this request is in place, check to see that you are reporting two different diagnosis codes. This is because you’re coding for two different procedures (the original surgery and the postoperative care) for two different reasons.

The primary diagnosis should tie into the reason for the surgery and anesthesia. The secondary diagnosis will be for the pain management; report G89.18 (Other acute postprocedural pain) for this.

Also: Track back the diagnosis codes being reported and checking whether some are denied more often than others.

Steer Clear of Submitting 64487 With 64488

You cannot submit 64487 (Transversus abdominis plane [TAP] block [abdominal plane block, rectus sheath block] unilateral; by continuous infusion[s] [includes imaging guidance, when performed]) on the same claim as 64488 (Transversus abdominis plane [TAP] block [abdominal plane block, rectus sheath block] bilateral; by injections [includes imaging guidance, when performed]).

Here’s why: Correct Coding Initiative (CCI) edits list 64487 as a Column 2 code with 64488 as the associated Column 1 code. That means the work of 64487 is included in the work of 64488; you only bill 64488. The edits do not allow you to
append a modifier to “break” the edit pair and report both codes.

**CRNAs Must Sign Off on Their Own Documentation**

Show your providers this information from the CMS State Operations Manual: “All entries in the medical record must be dated, timed, and authenticated, in written or electronic form, by the person responsible for providing or evaluating the service provided.”

**In other words:** If the CRNA is providing a service to the patient and documents that service within a hospital medical record, CMS regulations require the CRNA to authenticate that entry.

**Go With 00940 for Manual Uterine Inversion**

The CPT® procedure code for a manual inversion is “unlisted,” but remember that doesn’t always mean the anesthesia code is also “unlisted.” If the physician was able to manually re-insert as indicated by your question, anesthesia code 00940 (*Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium) not otherwise specified*) would be appropriate. If this was an emergency situation and you have clear documentation of such, you might also be justified in adding +99140 (*Anesthesia complicated by emergency conditions [specify] [List separately in addition to code for primary anesthesia procedure]*) to the claim.

- Published on 2018-01-01