Capture TPIs With Injections and More, Thanks to Edit Reversals

CCI 15.3 zeroes in on moderate sedation, but allows for more unbundling.

The latest Correct Coding Initiative (CCI) edits delete previous CCI edits for many acute postoperative pain management codes, and change modifier indicators for some of the most common pain management procedures. CCI 15.3 went into effect Oct. 1 and includes thousands of new, swapped, and terminated code pairs you need to implement now in order to file the correct codes and get reimbursed accordingly.

Clue In to Modifier Indicator Changes With Biggest Impact

“The big changes for anesthesia and pain management involve the change from a ‘0’ modifier indicator to a ‘1’ modifier indicator,” says Marvel J. Hammer, RN, CPC, CCS-P, PCS, ACS-PM, CHCO, owner of MJH Consulting in Denver. Having a “1” modifier indicator means you can append a modifier and bypass the bundling edits, thus gaining clearance to report both procedures.

Example: CCI 15.3 lists trigger point injections 20552 (Injection[s]; single or multiple trigger point[s], 1 or 2 muscle[s]) and 20553 (… single or multiple trigger point[s], 3 or more muscle[s]) as Column 1 codes. Now you can append modifiers to bypass the edits for trigger point injections and Column 2 codes representing some of your most common procedures:

• 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)
• 64408 — Injection, anesthetic agent; vagus nerve
• 64410 — … phrenic nerve
• 64435 — … paracervical (uterine) nerve.

Faster filing: “One important reminder is that the modifier must be appended to the Column 2 code and not the lower relative value unit (RVU) code,” Hammer says. In the example above, the trigger point injection codes carry a lower RVU. If you append the modifier to the Column 1 code instead of the Column 2, however, the carrier will deny your claim. The change is retroactive back to April 1, 2009.
Other pairs with modifier indicator changes involve Column 1 codes 27096 (Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid), 36557 (Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; younger than 5 years of age), 36558 (... age 5 years or older), and 36560-36566 (Insertion of tunneled centrally inserted central venous access device ...).

All the modifier indicator changes are retroactive to April 1, 2009.

Watch Your Moderate Sedation Opportunities

CCI 15.3 includes 18,320 new edit pairs, according to a summary report by Frank Cohen, PA, of MIT Solutions Inc. in Clearwater, Fla. “The overwhelming majority have a modifier indicator of ‘0,’ meaning you cannot use a modifier even if you think it is appropriate,” Cohen stated in a press release.

The most common codes being paired in new edits are for some moderate sedation services:

- 99148 — Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; younger than 5 years of age, first 30 minutes intra-service time

- 99149 — ... age 5 years or older, first 30 minutes intra-service time

- +99150 — ... each additional 15 minutes intra-service time (List separately in addition to code for primary service).

“Note that the majority of the new edits were for moderate sedation performed by another physician instead of the performing surgeon,” Hammer says. “These new bundling edits make sense that the physician reporting the surgical procedure code should not be able to report these particular moderate sedation codes that require a different provider performing the moderate sedation services.”

Pain practices: Anesthesiologists provide anesthesia during procedures, not moderate sedation — which means you wouldn’t be reporting 99148-99150 anyway. But you’re in a different situation when coding pain management. Your pain management specialist becomes the “surgeon” when administering injections, so you might have reported moderate sedation for some procedures in the past.

Switch the Codes in These Pairs

As if keeping up with new edits isn’t tricky enough, as an anesthesia or pain management coder you also have “swapped edit pairs” to change in your system.
This part of CCI 15.3 includes common procedures, such as 64450 (Injection, anesthetic agent; other peripheral nerve or branch) with 20550 (Injection[s]; single tendon sheath, or ligament, aponeurosis [e.g., plantar “fascia”). The Column 1 and Column 2 designations for the affected pairs have flip-flopped, so pay special attention to which procedure is now comprehensive versus component.

“This is a really important point,” Hammer notes. “If the provider puts the modifier on the Column 1 code in error, the Medicare contractor will deny the Column 2 code and not allow processing for payment.”

Example: Previous CCI edits listed 20550 in Column 1 and 64450 in Column 2. CCI 15.3 reverses those places, with 64450 in Column 1 and 20550 in Column 2, back to an effective date of Jan. 1, 1996.

Check Out the CMS Explanation

Niles R. Rosen, MD, medical director of the National Correct Coding Initiative, wrote the American Society of Anesthesiologists on behalf of CMS, explaining the Oct. 1 CCI changes before they went into effect. Highlights of the letter included:

• “CMS will modify the edits bundling epidural injection and nerve block CPT codes into certain

injection/aspiration procedures (CPT codes 20550-20553, 20600-20612, and 27096) so that all edits will allow use of NCCI-associated modifiers. If a provider performs a nerve block or epidural injection unrelated to anesthesia for one of the other listed procedures, the epidural injection or nerve block code may be reported with an NCCI-associated modifier.”

• “CMS will modify the edits bundling epidural injection and nerve block CPT codes into insertion of tunneled centrally inserted central venous access/catheter procedures (CPT codes 36557-36566) so that all edits will allow use of NCCI-associated modifiers.”

• “CMS will delete the edits bundling epidural injection and nerve block codes into CPT codes 31500, 36555, 36556, 36568, 36569, 36620, 36625, 93503, 93561, and 93562.”

Full details: You can read the complete letter on the ASA’s website (www.asahq.org). Simply click on “Practice Management” to reach the latest ASA news and scroll down to “ASA wins reconsideration of CCI edits” dated July 2, 2009.

Curb Your Excitement Over Terminated Edits

Most CCI 15.3 deletions apply to non-covered procedures.

At first glance, one bright spot in Correct Coding Initiative (CCI) version 15.3 could be the list of terminated code pairs, especially if your pain management provider performs IDET — but don’t get too excited too soon.

The report terminates many previous coding pair edits associated with code 22526 (Percutaneous intradiscal electrothermal annuloplasty, unilateral or bilateral including fluoroscopic guidance; single level) including:

• Many somatic nerve injection procedures (64400-64483)
• All sympathetic nerve injections (64505-64530)
• Transesophageal echocardiography monitoring (93318, Echocardiography, transesophageal [TEE] for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing [continuous] assessment of [dynamically changing] cardiac pumping function and to therapeutic measures on an immediate time basis).

CCI 15.3 indicates that you can code for these paired procedures retroactive to April 1, 2009 — but there’s a catch.

“Thermal intradiscal procedures, including IDET, are non-covered effective Sept. 28, 2008, based on a Medicare National Coverage Determination (NCD) policy,” says Marvel J. Hammer, RN, CPC, CCS-P, PCS, ACS-PM, CHCO, owner of MJH Consulting in Denver. “It isn’t necessary to have CCI edits if the Column 1 code is not covered, so the bundling edit deletions make sense.”
News You Can Use: Implement Your Swan-Ganz Boost

 ► Updated MPFS includes pay hike for catheter placement.

The October update to the 2009 Medicare Physician Fee Schedule (MPFS) database included good news for anesthesiologists: an increase in practice expense relative value units (RVUs) for 93503 (Insertion and placement of flow directed catheter [e.g., Swan-Ganz] for monitoring purposes).

The increase applies only when your anesthesiologist places the Swan-Ganz for monitoring purposes in a facility setting, but don’t let that bother you. “A Swan-Ganz catheter placement is a highly invasive procedure usually performed for patients requiring intensive care,” says Scott Groudine, MD, professor of anesthesiology at Albany Medical Center in New York. “A facility setting would be the only appropriate location.”

The change went into effect Oct. 5 and bumped the RVUs from 0.00 to 0.75. That means reimbursement of $139.23 for 93503, an increase of approximately $27.05 (before geographic adjustments). CMS says the change is effective for services provided on and after Jan. 1, 2009.

Next steps: Getting the extra reimbursement is up to you, because payers are not required to review their files and pay past claims. CMS has instructed payers to adjust claims that are brought to their attention, however, so sift through your records and refile accordingly.


Master Moderate Sedation Coding With These Easy Steps

 ► CCI 15.3 will have you watching provider involvement and documentation.

Considering the heavy focus on moderate sedation in the latest round of Correct Coding Initiative (CCI) edits, every coder should be up to date on when — and how — to correctly report moderate sedation services. By focusing on the providers and documentation of their roles, you’ll be on your way to claims success.

Learn the Moderate Sedation Ground Rules

It’s easy to confuse the various levels of sedation your physician might provide, so start with the basics:

• Anesthesiologists don’t provide moderate sedation. As the American Society of Anesthesiologists (ASA) points out, “It is important to note that anesthesiologists provide anesthesia (0XXXX codes) services. The moderate sedation codes were developed for cases where non-anesthesiologist physicians sedate patients” (December 2005 ASA newsletter).

• Your physician might provide moderate sedation under different circumstances. “When an anesthesiologist is performing a nerve block/injection procedure, he or she is classified as the ‘surgeon,’” says Joanne Mehmert, CPC, CCCPM, ACS-PM, of Joanne Mehmert and Associates in Kansas City, Mo. Once your provider shifts from an anesthesia provider role to the provider (or surgeon) performing the service, you’re in the realm of moderate sedation.

• You still need a qualified independent observer present in addition to the physician completing the service. The same physician cannot safely sedate the patient, monitor his or her condition, and perform the diagnostic or therapeutic service. Another qualified observer must be present during the procedure to monitor the patient and assist in sedation services.

• Moderate sedation does not include minimal or deep sedation. “CPT makes it clear that the moderate sedation codes are for sedation other than those described by the anesthesia codes,” says Maggie M. Mac, CPC, CEMC, CHC, CMM, ICCE, consulting manager for Pershing, Yoakley and Associates in Clearwater, Fla. “Moderate sedation does not include minimal sedation (anxiolysis), deep sedation, or monitored anesthesia care (MAC).”

You Be the Coder

Learn Crosswalks for Endoscopy Procedures

Question: Our group is looking to expand and start doing anesthesia for general and/or MAC anesthesia for colonoscopy, laparoscopic gallbladder, and EGD (Esophago-gastro duodenoscopy). What are the correct codes for these?

Florida Subscriber

Answer: Consider your answer carefully, then turn to page 95.
Choose Code Family Based on Involvement

CPT divides moderate sedation codes into two families. “Both sets of codes are then further broken down based on the age of the patient and incremental time,” Mac says.

- If the same physician provides moderate sedation and performs the procedure, choose from 99143-+99145 (Moderate sedation services [other than those services described by codes 00100-01999] provided by the same physician 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 ...). For example, pain management providers often report 99144 in conjunction with injection procedures such as radiofrequency destruction 64622-64627 (Destruction by neurolytic agent, paravertebral facet joint nerve ...).

- If different providers perform the service and oversee the moderate sedation, code from 99148-+99150 (Moderate sedation services [other than those services described by codes 00100-01999], provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports ...) instead. You could possibly report these codes in addition to procedures, such as MRIs or spinal taps for children or other non-Medicare patients (since CCI edits regarding moderate sedation might not affect reporting for non-Medicare cases).

4 Final Tips Help Clarify Documentation Details

Every detail supporting moderate sedation is crucial, considering how closely payers scrutinize the claims. Keep these final tips in mind before filing:

- Don’t report moderate sedation when the procedure code has a bull’s eye symbol beside it in the CPT manual (such as 22526-22527 for percutaneous intradiscal electrothermal annuloplasty, or IDET). For a quick look at procedures that include moderate sedation, see Appendix G in your CPT book.

- Because you’re dealing with time-based codes, calculate the time correctly. Intraservice time requires the surgeon’s continuous face-to-face attendance, Mehmert says. Calculate the time from when the surgeon is present (when the sedation agent is administered) until the surgeon is no longer present. “The nursing records and physician’s report of service should document the time that the physician is personally present with the patient,” Mehmert adds.

- Assign the correct add-on code when the service lasts longer than 30 minutes. Codes +99145 and +99150 have the same descriptor ending (... each additional 15 minutes intra-service time [List separately in addition to code for primary procedure]), so be sure to match the add-on code with the appropriate base code.

- Check with your payer about moderate sedation reimbursement. “Codes 99143-99150 are still carrier-priced with no relative value units (RVUs) assigned, and there is no change in the proposed Medicare Physician Fee Schedule,” Mehmert says. Some payers (such as Highmark Medicare) never allow separate payment for anesthesia service when the same physician furnishes the medical or surgical service. Translation: Payers set their own reimbursement for moderate sedation. Check your Medicare contractor’s Web site for information so you’ll know what to expect.

Note: Looking for an easy way to distinguish the various levels of sedation? To receive an easy-to-follow comparison chart, email the editor (leighd@eliresearch.com) with “Sedation Chart” in the subject line.

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If two physicians participate in the procedure, report 62311 (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; lumbar; sacral [caudal]) for the physician administering the epidural injection. Then submit 01992 (Anesthesia for diagnostic or therapeutic nerve blocks and injections [when block or injection is performed by a different provider]; prone position) for the additional professional who provided anesthesia service during the injection procedure.

**62311 With 01992 Depends on Providers**

**Question:** Can I bill 01992 for anesthesia for 62311?

**Answer:** It depends on who performed the epidural injection and who performed the “anesthesia” service. One physician cannot report both the anesthesia services and the surgical procedure if he performs the epidural injection (that becomes a case of conscious sedation instead of anesthesia administration).
S1 facet joint. Anatomic research has shown that as untrue. However, if physicians inject the S1 communicating branch, they are still blocking only the L5-S1 facet joint. You don’t report additional units of service for the additional injection.

Because of that, your provider blocked only two bilateral spinal levels, based on the information you share.

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**NovaSure Hysteroscopy Crosses to 00952**

**Question:** What surgical and anesthesia codes should I use for NovaSure?

Montana Subscriber

**Answer:** NovaSure is an ablation of the endometrial lining of the uterus. The surgical code is 58563 (Hysteroscopy, surgical; with endometrial ablation [e.g., endometrial resection, electrosurgical ablation, thermoablation]), which crosses to 00952 (Anesthesia for vaginal procedures [including biopsy of labia, vagina, cervix or endometrium]; hysteroscopy and/or hysterosalpingography).

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**Endoscopic Lumbar Nerve Decompression**

**Question:** One of our physicians is looking into “endoscopic lumbar spinal nerve decompression.” One of the medical device representatives indicated he could bill it like the lateral extraforaminal approach for lumbar decompression, but I haven’t found much information. What’s your advice?

Wyoming Subscriber

**Answer:** Despite what you physician might have heard, your most appropriate choice probably is 64999 (Unlisted procedure, nervous system). Many pain management providers are being introduced to different endoscopic approach systems. The

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**Follow These Examples for P Modifier Usage**

**Question:** What tips can you offer on distinguishing between CPT anesthesia physical status modifiers?

Pennsylvania Subscriber

**Answer:** The American Society of Anesthesiologists (ASA) doesn’t fully define the physical status modifiers because their use is based on clinical decisions the anesthesia provider makes for each patient. Your provider assigns a physical status modifier during the pre-anesthesia assessment.

Some physicians are better at documenting conditions to support physical status than others, but keep these examples in mind as a way to gauge your own cases:

- **P1 (A normal healthy patient)** is generally a healthy patient who presents with minimal risks.
- **P2 (A patient with mild systemic disease)** applies to patients with conditions such as controlled diabetes.
- **P3 (A patient with severe systemic disease)** points to conditions such as severe diabetes with vascular complications.
- **P4 (A patient with severe systemic disease that is a constant threat to life)** and P5 (A moribund patient who is not expected to survive without the operation) both represent very high risk, sick patients or those in trauma situations.

Assigning physical status modifiers is very individualized and the information you find from one place to another might conflict. If you have questions, check with your anesthesiologist or nurse assistant for clarification.

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You Be the Coder

**Question on page 92**

Learn Crosswalks for Endoscopy Procedures

**Answer:** The codes you’ll need are:

- Colonoscopy: 00810 (Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum)
- Laparoscopy: 00790 (Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; not otherwise specified)
- EGD: 00740 (Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum).

Many carriers have special policies regarding reimbursement for anesthesia during endoscopy. Check with your local carriers to ensure your documentation supports what the insurer requires.
AMA confirms that the descriptors for lumbar decompression procedures, such as those mentioned to your physician (63055-+63057, Transpedicular approach with decompression of spinal cord, equina and/or nerve root[s] [e.g., herniated intervertebral disc], single segment ...) do not include an endoscopic technique and should not be used to report this type of approach.

If the provider doesn’t complete the laminectomy (hemilaminectomy) required to meet the criteria for reporting 63020-+63035 (Laminotomy [hemilaminectomy], with decompression of nerve root[s], including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, including open and endoscopically-assisted approaches ...), the AMA directs you to report the “unlisted” procedure code.

Report J1885, 96372 for Toradol Injection

**Question:** How should I bill for an intramuscular injection of 60 mg of Toradol and calculate the medication units?

**Georgia Subscriber**

**Answer:** The correct procedure code is 96372 (Therapeutic, prophylactic, or diagnostic injection [specify substance or drug]; subcutaneous or intramuscular). Then report HCPCS code J1885 (Injection, ketorolac tromethamine, per 15 mg) for the medication.

Because the descriptor specifies a medication amount, one unit equals 15 mg. To calculate the units, divide the total mg administered by 15. For example, in this case you’ll bill with four units of service as your physician injected 60 mg of Toradol.

— 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. 

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