

Anesthesia & Pain Management Coding Alert

Your practical adviser for ethically optimizing coding, payment, and efficiency in anesthesia and pain management practices

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Clear 1 Line for Proper Swan-Ganz Coding

▶ **Reporting one placement will prevent incorrect double billing of 93503.**

The global anesthesia codes include many services, but when your anesthesiologist places a Swan-Ganz catheter, you'll need to know when you should — and shouldn't — report 93503 (*Insertion and placement of flow directed catheter [e.g., Swan-Ganz] for monitoring purposes*) separately. Follow these expert tips to ensure your catheter coding is spot-on.

Don't Assume Every CVP Uses Swan-Ganz

When your anesthesiologist is involved in an extensive heart procedure, he likely places a central venous pressure (CVP) catheter. The line is most often placed in the patient's superior vena cava, and may be used for other purposes, including IV fluid delivery, to adjust the patient's blood volume, or for central drug infusion.

In addition, your anesthesiologist may place a Swan-Ganz catheter (SGC), also known as a pulmonary artery (PA) catheter. This catheter can monitor pulmonary artery pressure, plus measure cardiac output and other cardiovascular functions. "Swan-Ganz is for specific monitoring," and central access, says **Janice Lienhard, CPC**, a coder in New Jersey. The SGC has multiple ports for central circulation access, including an regional anesthesia (RA) port, PA port, CVP port, and possibly the main line or "introducer."

What it means to coding: If documentation shows that your anesthesiologist placed a PA catheter, you'll report 93503, in addition to the appropriate anesthesia code.

Reason: When an anesthesiologist places an SGC line, he runs it through the CVP line. So when the CVP line is inserted as part of the procedure of inserting an SGC, the CVP line is considered a component of the line placement, and is not reimbursable. Only the Swan-Ganz line is reimbursable, Lienhard says.

Modifier 59 Use Is Possible

There are many instances where the physician will use both CVP line and a Swan-Ganz catheter in the same heart case for different reasons.

Example: Your anesthesiologist places a Swan-Ganz line in order to monitor cardiac output, and place a CVP line separately because of the need for multiple central vein IV access.

If two separate lines for the procedure are documented on the medical record, you can code both and expect separate reimbursement. Report 93503 and 36556 (*Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older*). Since

Collect Your Extra \$\$ Before Time Expires

In October 2009, the Medicare Physician Fee Schedule (MPFS) included a bump in relative value units (RVUs) for 93503. The increase applies when your anesthesiologist places a Swan-Ganz for monitoring purposes in a facility setting (which is where this procedure would normally occur).

This increase reflected a change in practice expense for reimbursing CVP lines versus Swan-Ganz lines placed after January 1, 2009. CVP line placement is a component of SGC insertion and a lower-risk procedure, yet because of the differences in the calculations of the RVUs payers were paying CVP at the higher value, says **Kelly Dennis, MBA, ACS-AN, CANPC, CHCA, CPC, CPC-I**, owner of Perfect Office Solutions in Leesburg, Fla. After the October change, Swan-Ganz now pays approximately \$27 more per placement than before, according to a notice on the Web site of the American Society of Anesthesiologists (ASA, www.asahq.org/news/asanews090309.htm).

Don't delay: Although this increase in reimbursement of SGC went into effect October 5, 2009, the change is retroactive to January 1, 2009. Medicare contractors will not go back and correct this underpayment, so if you want credit for the adjustment, it's up to you to resubmit affected claims. Services provided in federal fiscal year 2009 (which runs from October 1, 2008 to September 30, 2009) are due by December 31, 2010. □

you need to show that the CVP line is separate, append modifier 59 (*Distinct procedural service*) to 36556. If the insertion sites are different, this is an obvious indication that the CVP was separate from the SGC.

Roadblock: You can't assume that just because two lines were placed that you are reporting and billing for two codes. You should find clear documentation showing that your anesthesiologist placed a CVP line, followed by the Swan-Ganz, and note that the CVP was placed as part of the SGC insertion.

"If a coder doesn't realize these are done through the same access site, and that they aren't separately reportable when this happens, they will incorrectly add a 59 modifier to the CVP code and report both," says **Leslie Johnson, CCS-P, CPC**, director of coding and education with Medi-Corp Inc. in Cranford, N.J. and owner of the billing and coding Web site AskLeslie.net.

Patient Condition Points to Medical Necessity

Your anesthesiologist might typically place a Swan-Ganz in patients who have some type of cardiac condition, or whose cardiac function might be compromised prior to or during surgery.

Your anesthesiologist's documentation should include the specific reason the monitoring is necessary. A diagnosis such as congestive heart failure (428.0) would support the use of the Swan-Ganz monitor. □

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CCI 16.1 Update:

Fluoroscopic Guidance Leads Your Q2 Update List

► **Also, watch for a swapped modifier when reporting a GON block.**

Pain management coders won't be able to miss the new edits the Correct Coding Initiative (CCI) has included for fluoroscopic guidance. If you're not up on the changes in version 16.1, you may try to separately report fluoroscopic guidance. The new bundling edits won't allow as of April 1, 2010.

Version 16.1 is the second CCI update of the year. This version includes 2,054 new active pairs and 1,947 modifier changes, says **Frank D. Cohen, MPA, MBB**, senior analyst with MIT Solutions, Inc. in Clearwater, Fla. Here's what you need to know about the top 16.1 edits that will affect your pain management practice.

Look Before You Leap With Fluoroscopic Guidance

Version 16.1 bundles one fluoroscopic needle guidance code — 77002 (*Fluoroscopic guidance for needle placement [e.g., biopsy, aspiration, injection, localization device]*) — into several pain management procedures. Some you might expect and some may surprise you.

One new bundle won't let you report 77002 with 62267 (*Percutaneous aspiration within the nucleus*

pulposus...). CPT includes a parenthetical note directing providers to report 77003 (*Fluoroscopic guidance for localization of needle or catheter tip for spine or paraspinous procedures...*) for image guidance for 62267 so the new edit bundling 77002 as a column 2 code into 62267 makes sense, says **Marvel J. Hammer, RN, CPC, CCS-P, PCS, ACSPM, CHCO**, owner of MJH Consulting in Denver.

Check it out: CCI 16.1 also includes edits that bundle 77002 as a column 2 code into both 62268 (*Percutaneous aspiration, spinal cord cyst or syrinx*) and 62269 (*Biopsy of spinal cord, percutaneous needle*). Both of these column 1 codes include a note in the 2010 CPT codebook directing providers to use 77002 for radiologic guidance.

The new version also includes bundling edits between 77002 and several of the neurolytic destruction codes, including 64620 (*Destruction by neurolytic agent, intercostal nerve*).

Code 77003 is also bundled as a column 2 code into many of the autonomic nerve injection codes, such as 64510 (*Injection, anesthetic agent, stellate ganglion [cervical sympathetic]*).

Beware: "With these new CCI edits, if the physician only performs the column 1 pain management procedure code along with the column 2 fluoroscopic guidance, it would not be compliant to append a modifier to bypass this edit," Hammer says.

Swap the Modifier on GON and Ligament Blocks

One example of the importance of swapped pairs in CCI 16.1 occurs with greater occipital nerve (GON) injections. If your pain management specialist performs an injection on a patient's GON (64405, *Injection, anesthetic agent; greater occipital nerve*) and also performs a tendon injection in a separate anatomic location, such as the thumb for De Quervain's syndrome (20550, *Injection[s]; single tendon sheath, or ligament, aponeurosis [e.g., plantar "fascia"]*), you'll need to know that the two codes have switched places.

The result: As of April 1, 20550 is now the column 2 code, with 64405 in column 1. "It makes more sense, because you don't do greater occipital nerve injections as an anesthetic for the tendon injection," Hammer says. This edit carries a "1" modifier indicator.

Reminder: A modifier indicator of "0" means that you cannot unbundle or break the pair with any modifier. A modifier indicator of "1" means that you

(Continued on next page)

You Be the Coder

Find the Missing EGD Reimbursement Link

Question: *Our anesthesiologist provided anesthesia during an esophagogastroduodenoscopy (EGD) procedure, at the request of the attending physician. We coded the anesthesia portion with 00810. A note in the documentation mentions the request was due to the patient's symptoms, but no other details were provided. The claim we submitted was denied, but we followed all of the other guidelines provided by the payer, including proof that the anesthesiologist administered Propofol. What did we do wrong?*

New York Subscriber

Answer: Turn to page 39. □

may be able to unbundle if medical necessity calls for it. Be sure you have the proper documentation from your pain management specialist's notes, says **Eman Danial, CPC**, billing manager with Westgate Pain Management Group in Cleveland. With this new switch, the new column 1 code will be processed for payment, while 62365 will be denied.

Reasoning: The logic behind this kind of CCI edit is that the more extensive procedure is now in column 1.

Note Modifier Placement on Trigger Point Injection

You should now check CCI for swaps involving 64450 (*Injection, anesthetic agent, other peripheral nerve or branch*). For example, check when your pain management specialist performs a sacroiliac ligament injection, reported with 20550 or an ulnar nerve block at the elbow for cubital tunnel syndrome (354.2, *Lesion of ulnar nerve*).

Due to the new swap, you now need to append the modifier to bypass the CCI edit to the ligament injection code 20550 rather than 64550. By appending modifier 59 (*Distinct procedural service*) you're indicating that the physician performed the injections in different anatomic locations. □

Employ Modifier 53 For Discontinued Anesthesia Services

► **Pain management specialties might make use of modifier 52 as well.**

The situation is bound to happen: A patient undergoing surgery has complications, and your anesthesiologist must stop his services. Are you prepared to recognize a situation that calls for modifier 53 (*Discontinued procedure*) or even modifier 52 (*Reduced services*)? Learn the specific criteria for reporting each modifier to ensure successful coding every time.

Patient Status Often Determines 53 Use

You will use modifier 53 when a procedure ends due to a threat to the patient's well-being or other extenuating circumstances. For example, the surgeon performs a preop assessment, but during the evaluation he detects a carotid bruit (785.9, *Other symptoms involving cardiovascular system*), so he delays the surgery indefinitely until a better evaluation can be made.

Documentation clue: You can only use modifier 53 after anesthesia administration and/or a surgical preparation took place, and the procedure was actually started. You should consider the procedure discontinued when anesthesia ends early. "If any modifier is to be used, 53 is the most appropriate," says **Scott Groudine, MD**, professor of anesthesiology at Albany Medical Center in New York.

Example: A patient is being prepared for a routine surgery but has not yet been induced. Another patient develops chest pains and must be induced for surgery immediately, so your anesthesiologist must cancel the first procedure to attend to the second patient's procedure. You should report 01999 (*Unlisted anesthesia procedure[s]*) with modifier 53, Groudine recommends. You should let the payer reduce the fee on services to which you attach modifier 53. Otherwise, you risk additional payment reductions.

Bottom line: When reading the operative report of a discontinued service, simply look at the reason for the discontinuance. If it indicates an extenuating circumstance occurred, use modifier 53.

Facility difference: If you are coding only for facility payment, such as for an ambulatory surgical center, use modifiers 73 (*Discontinued outpatient procedure prior to anesthesia administration*) or 74 (*Discontinued outpatient*

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procedure after anesthesia administration) instead of modifier 53.

Turn to 52 for ‘Physician Discretion’

Although modifier 52 may not apply to anesthesia, it might apply to pain management specialists. You should use modifier 52 when your pain management specialist, while performing a service or procedure, chooses to partially reduce or eliminate a portion of the code’s requirements. “Under certain circumstances a service or procedure is reduced at the physician’s discretion. This decision can be made prior to or during the procedure.

You should use modifier 52 when services your pain management specialist performs are less than those described by the code. In such a case, you must be certain that there is no designated CPT code to describe the lesser procedure.

Tip: Let the payer reduce the fee for the procedure when you use modifier 52. Do not apply the fee reduction on the claim. If you do, the payer may still reduce your reimbursement because of the modifier, and you may then receive a double fee reduction. □

READER QUESTIONS

Look for Medical Necessity for Lumbar Epidural

Question: *My anesthesiologist recently inserted a pre-operative lumbar epidural catheter prior to providing general anesthesia. I’m wondering why he performed the insertion that way, at that particular time. I’m also wondering, of course, if I can bill for it. What codes should I use?*

Florida Subscriber

Answer: You will use 62319 (*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 anesthetic, antispasmodic, opioid, steroid, other solution], epidural or subarachnoid; lumbar, sacral [caudal]*) to report this procedure. You should append modifier 59 (*Distinct procedural service*) to show the catheter procedure was separate from the anesthesia service. Your anesthesiologist’s documentation should also show that fact in order to prove medical necessity.

A lumbar epidural is traditionally inserted preoperatively, when the patient is able to assume the correct position for the insertion. This is usually done in the sitting position or with the patient lying on her side. Also, these blocks are inserted near the nerves of the spinal cord, so it is usually safer to do this in a patient who is awake. The patient would be able to tell your anesthesiologist if the needle is causing pain that could progress to nerve damage if unrecognized.

No Way Around Carrier’s Standby Policy

Question: *One of our anesthesiologists monitored a patient’s vital signs during excision of a tumor from the patient’s back. The monitoring was done from 7:47 p.m. to 8:07 p.m. The surgeon, not our anesthesiologist, was the one who administered the anesthetic at 7:48. The patient’s carrier (NGS Medicare) does not allow billing for standby services. Is there any way to be reimbursed for the anesthesiologist’s time?*

Kentucky Subscriber

Answer: In the situation as you describe it, the anesthesiologist is not actively participating in the case, so unfortunately there is no reasonable claim that can be made for this time period.

Most payers will deny standby services (99360, *Physician standby service, requiring prolonged physician attendance, each 30 minutes [e.g., operative standby, standby for frozen section, for cesarean/high risk delivery, for monitoring EEG]*), regardless of whether the claim involves another same-day charge, such as 99223 (*Initial hospital care, per day, for the evaluation and management of a patient ...*).

The Correct Coding Initiative edits do not bundle 99360 with 99223. Therefore, you do not technically need modifier 25 (*Significant, separately identifiable evaluation and management service by the same physician on the same day of a procedure or other service*). As you’ve already found out, the Medicare Physician Fee Schedule assigns a status indicator of “X” to 99360, which means standby service is excluded across the board. Any payer that uses these status codes as part of their claims processing will refuse to pay for 99360.

For more hints on standby coding, see “Availability is Key to Coding Standby” in *Anesthesia & Pain Management Coding Alert* Vol. 12, No. 3.

Documentation Is Key to Separate Injections

Question: *My anesthesiologist performed two post-procedure injections on a patient. Can I bill 62311 with 27096? If not, should I bill one code in favor of the other?*
North Carolina Subscriber

Answer: While performing 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]*) together with 27096 (*Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid*) is rare, the Correct Coding Initiative edits show that you may unbundle them with a modifier.

If you were to unbundle this pair, you need to append modifier 59 to 62311, because it is the column 2 code (the component code) to the more comprehensive code, 27096.

Note, however, that due to the rarity of these two codes being indicated/performed together, your documentation for proving medical necessity will have to be very clear.

Also note that this kind of procedure is performed for post-operative pain and is considered a surgical procedure. You shouldn't use any anesthesia crosswalk codes.

Stay Away From 01996 for Single-Shot Morphine

Question: *Our anesthesiologist provided an epidural to an OB patient for cesarean section. She used a specific brand-name preservative-free morphine. Should I use 01996 to code for use of the drug during the procedure?*
Arizona Subscriber

Answer: You would not report 01996 (*Daily hospital management of epidural or subarachnoid continuous drug administration*) because preservative-free morphines, such as Duramorph or Astramorph, are administered with a single application. So even though it is administered through the catheter, it is not administered continually as the code descriptor for 01996 indicates.

A preservative-free morphine, such as Duramorph, is often given spinally or by epidural for C-section pain or for large episiotomy repair. Physicians often mix Duramorph with the drugs given spinally for a cesarean section. If your anesthesiologist uses this technique, he

might list “spinal morphine” on the anesthesia record with other medications administered spinally.

Don't miss: The patient should have respiratory monitoring after administration, however, due to the risk of respiratory distress. So you would need to separately include 99231 (*Subsequent hospital care, per day, for the evaluation and management of a patient ...*). If your physician gave preservative-free morphine and subsequently managed the patient's post-op pain, you would then be able to bill 99231 on the first day of post-op care.

Remember: When you code this type of case, the original anesthetic includes the patient's first day of postoperative pain management — that is, the code you reported for the labor and delivery, such as 01967 (*Neuraxial labor analgesia/anesthesia for planned vaginal delivery [this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of epidural catheter during labor]*) and +01968 (*Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia [List separately in addition to code for primary procedure performed]*).

Occipital Lipoma Excision Points to 00300

Question: *One of our anesthesiologists recently provided services during an excision of an occipital lipoma. How should I code for this?*

Pennsylvania Subscriber

Answer: You should report 00300 (*Anesthesia for all procedures on the integumentary system, muscles and nerves of head, neck and posterior trunk, not otherwise specified*).

Note: The excisions made by the surgeon might be superficial, so verify whether your physician administered monitored anesthesia care (MAC) during the procedure. If so, you should check your payer's guidelines to determine whether to append modifier QS (*Monitored anesthesia care service*) to 00300.

Occipital lipoma is a benign tumor composed of fatty tissue that occurs on the back of the head. The tumor can be small and still require MAC, or be large and require general anesthesia or a scalp nerve block.

Certification Usually Required for 93312

Question: *I've heard different interpretations regarding certification guidelines for an anesthesiologist doing echocardiography. Some sources say the anesthesiologist has to be certified through the facility where he is working. I've also heard he has to have some form of national certification. Does the anesthesiologist have to be certified to do the procedure? And if he performs the exam, what codes would I use?*

Iowa Subscriber

Answer: Assuming your physician is credentialed to perform an echocardiography procedure, you might use 93312 (*Echocardiography, transesophageal, real-time with image documentation [2D] [with or without M-mode recording]; including probe placement, image acquisition, interpretation and report*), and use the crosswalk anesthesia code 01922 (*Anesthesia for non-invasive imaging or radiation therapy*).

Physicians and nurses have a "Delineation of Privileges" that outlines what procedures they are allowed to perform in facilities and/or offices based on training and skills. This is part of their credentialing process.

In order to determine if your anesthesiologist must be credentialed before performing the procedure, you'll need to check your hospital guidelines, and also check with your payers. There is no law requiring certification, but most hospitals require some training in echocardiography before credentialing a physician to use it.

Several payers, including United Healthcare, also require some form of credentialing in order to reimburse services like those covered by 93312.

The American Society of Echocardiography has published papers on the subject of credentialing, and offers the following: "A new cardiac sonographer entering the field must comply with the formal educational requirements specified by the applicable credentialing organization, and must fulfill those requirements through participation in a program recognized by the ASE." For more information from the ASE, visit www.asefiles.org/sonographerminimumstandards.pdf.

Newsletter Question or Comment?



If you have a question or comment about the contents of this publication, please contact the editor, Joshua Thines, at josht@inhealthcare.com.

You Be the Coder

Find the Missing EGD Reimbursement Link

(Question on page 35)

Answer: One key to the denial might be found in the lack of coding for the patient's condition. Your diagnosis code should indicate the co-existing medical condition that justifies your anesthesiologist's involvement in the case, not the gastrointestinal condition leading to the endoscopy.

You may want to consult with your anesthesiologist to verify that the patient had a condition such as:

- Parkinson's disease (332.0)
- Heart conditions (such as 410.xx, *Acute myocardial infarction* or 427.41, *Ventricular fibrillation*)
- Mental retardation (318.x)
- Seizure disorders (such as 780.39, *Other convulsions*)
- Anxiety (such as 300.0x, *Anxiety states*)
- Pregnancy
- History of drug or alcohol abuse.

These are just some of the conditions that payers may require to justify the presence of an anesthesiologist at a colonoscopy. ICD-9 2010 also has two codes to describe failed sedation attempts: 995.24 (*Failed moderate sedation during procedure*) and V15.80 (*Personal history of failed moderate sedation*). If your anesthesiologist's documentation confirms one of these conditions, 995.24 or V15.80 would also justify an anesthesiologist's involvement to most payers.

The conditions listed above constitute the medical necessity of anesthesia with the procedure. If you used a screening diagnosis or treatment of commonly found conditions instead of the clinical condition requiring anesthesia, payers will not pay you for these services.

Also note the number of other possible elements that may need to be met for proper reimbursement of EGD anesthesia, including documentation noting the patient's physical status. For example, some payers require a physical status modifier of P3 (*A patient with severe systemic disease*) or higher.

Caution: Including the diagnosis with your claim doesn't guarantee reimbursement. You might head off future denials by verifying EGD coverage with your payer beforehand. While EGD procedures are still a complex area for anesthesia coders, payers continue to have varying requirements for use of anesthesia in EGD procedures.

Good news: Your use of 00810 (*Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum*) is correct, based on when the physician likely introduced the endoscope. □

2 Anesthetic Blocks Need Modifier 59

Question: *Our anesthesiologist performed a suprascapular block injection while the surgeon performed a manipulation on a patient with complex regional pain syndrome. On the same day, the anesthesiologist performed a stellate ganglion block on the same patient. He explained to me the suprascapular block was necessary as not to disturb her other condition. Can these both be billed together?*

California Subscriber

Answer: You may be able to report 64418 (*Injection, anesthetic agent; suprascapular nerve*) with 64510 (*Injection, anesthetic agent; stellate ganglion [cervical sympathetic]*), using modifier 59 (*Distinct procedural service*) to show that a separate injection was performed.

You'll need to be able to prove medical necessity, so be sure to work with your anesthesiologist to provide the documentation you'll need.

As your anesthesiologist mentioned, local anesthetics are often injected in the area of the stellate ganglion in order to reduce symptoms from type I complex regional pain syndrome, also known as reflex sympathetic dystrophy. In addition, physicians may also use suprascapular nerve blocks to treat chronic shoulder pain.

— *Answers to You Be the Coder and Reader Questions were provided by Scott Groudine, MD, an Albany, N.Y., anesthesiologist; Kelly Dennis, MBA, ACSAN, CANPC, CHCA, CPC, CPC-I, president of Perfect Office Solutions in Leesburg, Fla.; and Marvel J. Hammer, RN, CPC, CCS-P, ACS-PM, CHCO, owner of MJH Consulting in Denver.* □

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