ASA Coding Update for 2009

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Norman A. Cohen, M.D.
Sharon K. Merrick, CCS-P

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Stanley W. Stead, M.D., M.B.A.

Dr. Stead is Chair of ASA’s Committee on Economics. He has served on the AMA CPT Editorial Panel from 2000-2008 and is now on the AMA CPT Assistant Editorial Board. In addition, he is ASA’s Alternate Member to the AMA/ Specialty Society RVS Update Committee. He is currently Clinical Professor of Anesthesiology and Pain Medicine at UC Davis Health System and President of the Stead Health Group, Inc. Dr. Stead originated the ASA CROSSWALK® and serves as its Editor. Dr. Stead has authored AMA’s publications on the Physician Quality Reporting Initiative (PQRI) for 2007 and 2008.
Norman A. Cohen, M.D.

Dr. Cohen is Chair of ASA's Section on Professional Practice, overseeing six ASA committees, including the Committee on Economics (COE). He has been a member of the COE since 1997, and chaired that committee from 2005-2007. Dr. Cohen served on the AMA RVS Update Committee (RUC) from 2000-2008, chairing both its Research Subcommittee and the E&M 2005 Five-Year Review Workgroup. He is an Assistant Professor of Anesthesiology and Peri-Operative Medicine at Oregon Health & Science University. He co-authored the textbook “Avoiding Common Anesthesia Errors,” and recently published an article on moderate sedation with Dr. Stead in the journal CHEST.

Sharon K. Merrick, CCS-P

Ms. Merrick has been ASA’s Coding and Reimbursement Manager since 2001. She oversees all coding-related matters for the ASA and is the society’s staff liaison to the AMA CPT Editorial Panel and the AMA/ Specialty Society RVS Update Committee. She received CPT’s Staff Liaison Award in 2006. Ms. Merrick has participated in coding panel discussions at the ASA Annual Meeting, spoken at the MGMA-AAA meetings and co-authored a chapter in ACCP’s publication Coding for Chest Medicine.
Poll #1

- We would like to know about you. Are you
  - 1. An anesthesiologist
  - 2. A practice administrator
  - 3. A coder/biller
  - 4. Other


- Anesthesia codes are part of CPT
  
  HIPAA Compliant

  Subject to CPT/RUC process
2009 Anesthesia Code Changes

Anesthesia Codes - Head

New Code 00211
Anesthesia for intracranial procedures; craniotomy or craniectomy for evacuation of hematoma

*Base unit value = 10*

Code 00211

• Code 00211 was created to address concerns over wide variety of surgical procedures reported under 00210

• The new code extracts the anesthesia procedures for craniotomy/craniectomy for evacuation of hematoma from code 00210 – *Anesthesia for intracranial procedures; not otherwise specified* - into their own code
2009 Anesthesia Code Changes

Anesthesia Codes – Intrathoracic (Cardiac)

Revised Code 00562
Anesthesia for procedures on heart, pericardial
sac and great vessels of chest; with pump oxygenator,
age 1 year or older, for all non-coronary bypass
procedures (eg, valve procedures) or for re-operation
for coronary bypass more than 1 month after original
operation

*Base unit value = 20*

2009 Anesthesia Code Changes

Anesthesia Codes – Intrathoracic (Cardiac)

Revised Code 00566
Anesthesia for direct coronary artery
bypass grafting; without pump oxygenator

*Base unit value = 25*
2009 Anesthesia Code Changes

Anesthesia Codes – Intrathoracic (Cardiac)

New Code 00567
Anesthesia for direct coronary artery bypass grafting; with pump oxygenator

*Base unit value = 18*

Codes 00562 and 00567

- Code 00562 was revised and new code 00567 was created to address concerns about the heterogeneity of surgical procedures reported under 00562
- 00562 revised to capture anesthesia work associated with more complex surgical procedures performed with pump oxygenator
- Some of these procedures did not exist when 00562 first developed
- 00567 created to describe anesthesia care for on pump CABG
2009 Pain Code Changes

Continuous Peripheral Nerve Blocks

- Revised Codes: 64416, 64446, 64448 and 64449
- Daily management reported separately with appropriate E/M code
- Global period changed from 10 to 0 days

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Revised Code 64416
Injection, anesthetic agent; brachial plexus, continuous infusion by catheter (including catheter placement)

2008 Work RVU: 3.85; Global: 10 days
2009 Work RVU: 1.81; Global: 0 days

Revised Code 64446
Injection, anesthetic agent; sciatic nerve, continuous infusion by catheter (including catheter placement)

2008 Work RVU: 3.61; Global: 10 days
2009 Work RVU: 1.81; Global: 0 days
2009 Pain Code Changes

Revised Code 64448
Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement)
2008 Work RVU: 3.36; Global: 10 days
2009 Work RVU: 1.63; Global: 0 days

Revised Code 64449
Injection, anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)
2008 Work RVU: 3.24; Global: 10 days
2009 Work RVU: 1.81; Global: 0 days

Catheter Implantation/Removal Codes

62350 – Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy
2008 Work RVU: 8.04; Global: 90 days
2009 Work RVU: 6.00; Global: 10 days

62355 – Removal of previously implanted intrathecal or epidural catheter
2008 Work RVU: 6.60; Global: 90 days
2009 Work RVU: 4.30; Global: 10 days
2009 Pain Code Changes

Reservoir/Pump Implantation/Removal Codes

62360 – Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir

  2008 Work RVU: 3.68; Global: 90 days
  2009 Work RVU: **4.28**; Global: 10 days

62361 – Implantation or replacement of device for intrathecal or epidural drug infusion; nonprogrammable pump

  2008 Work RVU: 6.59; Global: 90 days
  2009 Work RVU: 5.60; Global: 10 days

62362 – Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming

  2008 Work RVU: 8.58; Global: 90 days
  2009 Work RVU: 6.05; Global: 10 days

62365 – Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion nonprogrammable pump

  2008 Work RVU: 6.57; Global: 90 days
  2009 Work RVU: 4.60; Global: 10 days
2009 Pain Code Changes

Neurostimulators

63650 – Percutaneous implantation of neurostimulator electrode array, epidural
  2008 Work RVU: 7.57; Global: 90 days
  2009 Work RVU: 7.15; Global: 90 days***

63685 – Insertion or replacement of spinal neurostimulator pulse generator or receiver, direct or inductive coupling
  2008 Work RVU: 7.87; Global: 90 days
  2009 Work RVU: 6.00; Global: 90 days***

63688 – Revision or removal of implanted spinal neurostimulator pulse generator or receiver
  2008 Work RVU: 6.10; Global: 90 days
  2009 Work RVU: 5.25; Global: 90 days***

*** Anticipate CMS to issue technical correction re: global

2009 Medicare Physician Fee Schedule – Final Rule

• 2009 Conversion Factors

• 2009 PQRI
2009 Medicare Conversion Factors

<table>
<thead>
<tr>
<th></th>
<th>Anesthesia</th>
<th>RBRVS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>$16.1851</td>
<td>$37.8975</td>
</tr>
<tr>
<td>2008</td>
<td>$19.9698</td>
<td>$38.0870</td>
</tr>
<tr>
<td>2009</td>
<td>$20.9150</td>
<td>$36.0666</td>
</tr>
</tbody>
</table>

2009 Medicare Conversion Factor Calculation

Factors involved:
- H.R. 6331, the Medicare Improvements for Patients and Providers Act (MIPPA)
  - Positive SGR update of 1.1%
  - MIPPA mandated change in way CMS applies budget neutrality adjustment
- Requirement to calculate CF as if 2007 and 2008 increases had not been applied
Budget Neutrality Adjustment

- When changes in Fee Schedule cause shifts of more than $20 million, CMS is required to apply a budget neutrality (BN) adjustment
  - E/M and Anesthesia updates from Third Five Year Review exceeded this threshold

- In 2007 and 2008, BN adjustment mandated by the Five Year Review was applied to work relative value units for RBRVS services

- Adjustment applied to work portion of the anesthesia CF as anesthesia codes do not break down into work, practice expense and PLI components

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Budget Neutrality Adjustment

- ASA and almost all of medicine advocated that the BN adjustment be applied to conversion factors

- **SUCCESS:** MIPPA makes that happen

- Work intensive specialties like anesthesiology benefit
More ASA Victories

- **A historic 32 percent increase in the work portion of the anesthesia conversion factor.** This amounted to a 25 percent overall increase, which translates to an average of approximately $20,000 in increased Medicare payments to anesthesiologists for each year going forward.

- **Much-needed reform of the Medicare anesthesiology teaching rule beginning in 2010.** ASA successfully worked with Members of Congress to reverse the 50 percent payment penalty for teaching programs by including legislative language in H.R. 6331. This will amount to one-half billion dollars for teaching programs over 10 years.

- **A reprieve from SGR cuts.** ASA joined the rest of medicine to successfully lobby for an 18-month fix to the planned Medicare Sustainable Growth Rate formula (SGR) cuts. Instead of a 10.1 percent cut scheduled for 2008, physicians have seen a continued 0.5% positive update. Further, the 1.1 percent positive update included in the 2009 Physician Fee Schedule replaces a scheduled 15 percent cut.

POLL #2 PQRI Participation

In 2007, did you participate in PQRI and receive an incentive payment this year?

1. Yes - we participated, and **did** receive an incentive payment.
2. Yes - we participated, but **did not** receive an incentive payment
3. No
PQRI - Incentive Payments from 2007

- Distributed by the Carrier or A/B Medicare Administrative Contractor (MAC) - Issued beginning July 15, 2008
  - Some carriers were delayed in distributing incentive payments
  - If you bill to multiple carriers, you will receive a separate payment from each carrier
- Identified as:
  - Paper checks - an explanatory message on the P4R lump sum bonus payments that says: “This check is for a P4R payment.”
  - Electronic transmissions- provider adjustment code “LS” (lump sum) will appear in PLB03-1 on the outgoing 835
  - Tax Identification Number (TIN) Level Lump-Sum Payment

Final Rule - 2009 PQRI

- Secretary of HHS is required to publish a set of quality measures that eligible professionals may use to submit in 2009.
- PQRI becomes a permanent program under MIPPA and authorizes CMS to make incentive payments for satisfactorily reporting data on quality measures.
- 2009 payment for successful reporting: 2% of estimated total allowed charges for all services furnished during the reporting period
- E-prescribing quality measures now excluded from PQRI and are reported separately.
2009 PQRI Claims-Based Reporting Options for Individual Measures

<table>
<thead>
<tr>
<th>Reporting Mechanism</th>
<th>Reporting Criteria</th>
<th>Reporting Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims-based reporting</td>
<td>At least 3 PQRI measures, or 1-2 measures if less than 3 apply to the eligible professional, for 80 percent of applicable Medicare Part B FFS patients of each eligible professional.</td>
<td>January 1, 2009 – December 31, 2009</td>
</tr>
</tbody>
</table>

- PQRI in 2009 also includes reporting measures groups and registry-based reporting
- Helpful worksheets for organizing, collecting and reporting PQRI: www.ama-assn.org/pqri

PQRI 2009 - 153 Quality Measures

- CMS proposed a total of 175 quality measures for implementation into the PQRI program for 2009. After review of the comments received, the final set of PQRI measures is composed of 153 measures.
- 2009 measures specifications will be available on the www.cms.hhs.gov/pqri when finalized.
- EHR-based submission for reporting individual measures
  - CMS will test the submission of clinical quality data extracted from EHRs for 5 2008 measures and accept PQRI data from EHRs
  - CMS will pay the incentive payment based upon that submission for a limited subset of the proposed 2009 PQRI quality measures.
PQRI 2009 and beyond

• PQRI is Value-Based Pricing (VBP) = P4P, P4R
• If you want to know where PQRI is going, look to the Hospital Quality Initiative ......
  www.HospitalCompare.hhs.gov
• “Eligible hospitals that do not participate in ... will receive a reduction of 2.0 percentage points in their Medicare Annual Payment Update for fiscal year 2007.”
• “Based upon .... (program) withdrawal, ...hospitals Annual Payment Update will be reduced by 0.4% for the next fiscal year”

Final Rule - PQRI

• Measure specifications/instructions to be posted by 12/31/08 at www.cms.hhs.gov/pqri

• CMS will publically report the names of eligible professionals who satisfactorily submit quality data during the 2009 PQRI program
2009 Relative Value Guide®

- Relative Value Guide®
  - Anesthesia Guidelines
  - ASA Statements
  - Truncated ICD-9-CM
  - Coding Comments

Base Unit Value Change-Code 00142

- Anesthesia for procedures on eye; lens surgery
  - RVG Base Unit Value changes from 6 to 4 units
  - CMS Base Unit Value has always been 4
Base Unit Value Change - 00142

This code came forward as a result of the recently concluded Five Year Review in which the RUC’s review and analysis of the work component of an anesthesia service – using the ASA’s linear regression model to value the post-induction period and a building block approach to evaluate the work associated with all the other elements of an anesthesia service – resulted in a recommendation to increase the work component by 32%.

The analysis validated the base unit values for all anesthesia services except for 00142, 00210 and 00562. Codes 00210 and 0562 were referred to CPT for re-definition. Code 00142 was the subject of a RUC Work Survey. Survey results supported 4 base units.

RVG Coding Comments – Pediatric Codes

00326 Anesthesia for all procedures on the larynx and trachea in children younger than 1 year of age

00561 Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator, younger than 1 year of age

00834 Anesthesia for hernia repairs in the lower abdomen no otherwise specified; younger than 1 year of age

00836 Anesthesia for hernia repairs in the lower abdomen not otherwise specified, infants younger than 37 weeks gestation age at birth and younger than 50 weeks gestational age at time of surgery
RVG Coding Comments: Pediatric Codes

- RVG Comment: Base unit value takes patient age into consideration
- Base value includes work associated with code +99110 – Anesthesia for patient of extreme age, younger than 1 year and older than 70

RVG Coding Comments – Lower Abdominal, Extraperitoneal

00860 Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; not otherwise specified
00862 renal procedures, including upper one-third of ureter, or donor nephrectomy
00864 total cystectomy
00865 radical prostatectomy (suprapubic, retropubic)
00866 adrenalectomy
00868 renal transplant (recipient)
00870 cystolithotomy
RVG Coding Comments – Lower Abdominal, Extraperitoneal

- RVG Comment: Includes laparoscopy
- Comment added to make clear that laparoscopic approach does not automatically cross to code 00840 Anesthesia for intraperitoneal procedures in lower abdomen, including laparoscopy; not otherwise specified
- Laparoscopic approaches apply to 00860 when extraperitoneal

RVG Coding Comment - On pump CABG

00567 Anesthesia for direct coronary artery bypass grafting; with pump oxygenator

(Multiple RVG Comments)
**RVG Coding Comment – On pump CABG**

- RVG Comment: If procedure involves both coronary and valve work, report code 00562

- Consistent with concept re: multiple surgical procedures performed under a single anesthetic

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**RVG Coding Comments – Hysteroscopy/Hysterosalpingography**

00952  Anesthesia for vaginal procedures (including biopsy of labia, vagina, cervix or endometrium); hysteroscopy and/or hysterosalpingography

*(Revision to existing comment)*
RVG Coding Comments – Hysteroscopy/Hysterosalpingography

• RVG Comment: Includes uterine brachytherapy when hysteroscope is used to place brachytherapy devices

• Clarifies that 00952 is reported when a scope is used to place the device

RVG Coding Comment - Thoracotomy

00540 Anesthesia for thoracotomy procedures involving lungs, pleura, diaphragm, and mediastinum (including surgical thoracoscopy); not otherwise specified

(Comment deleted)
**RVG Coding Comment - Thoracotomy**

- **RVG:** For diagnostic thoracoscopy report code 00528 or 00529. For surgical thoracoscopy report code 00540 or 00541.

- Comment was added when code 00528 was revised and 00529 was new. Intended to identify differences between 00528/00529 and 00540/00541. Codes firmly established and comment no longer necessary.

**New ASA Statements**

- **Fluoroscopic Guidance for Spinal Injections**

- **Reporting Postoperative Pain Procedures in Conjunction with Anesthesia**

These and all ASA Statements available at [www.asahq.org](http://www.asahq.org)
1. Current Procedural Terminology® (CPT) is a publication of the AMA. The CPT Editorial Panel prepares the publication with assistance of physicians representing all specialties of medicine, and many third party and governmental agencies. All CPT codes conform to the same rules, and may be used by any physician regardless of the specialty.

2. CPT separates the performance of diagnostic or therapeutic procedures from providing the anesthesia for these procedures.
   - CPT codes 00100-01999 are the anesthesia codes while
   - CPT codes (10021-69990, and 90281-99607) represent the procedures.
3. The anesthesia codes 00100 – 01999 are *not* to be used to report anesthesia provided by the operating physician. When an anesthesiologist places a block or line, s/he is, in fact, the operating physician for the procedure.

- Per CPT guidelines, when the person performing the procedure administers the anesthetic for that procedure, the anesthesia is reported by appending modifier 47, *Anesthesia by Surgeon*, to the procedure code.

3. (Continued)

- Anesthesia provided by the surgeon is **bundled into the payment** of the surgical service.
- Anesthesiologists may be tempted to use modifier 47 with the line insertions to report the sedation (or general anesthesia) **time**, but by CPT convention, this is **not a payable service**.
Lines, Blocks, TEE and Anesthesia Time

4. Placement of arterial lines, central venous pressure (CVP) or pulmonary artery (PA) catheters, blocks or epidurals done for post-operative pain and diagnostic trans-esophageal echocardiography (TEE) are considered separate from anesthesia services. • As these procedures are separate and distinct from the anesthesia work, one should append modifier 59, Distinct Procedural Service, to those procedures when reported with an anesthesia service.

5. AMA and the Centers for Medicare and Medicaid Services (CMS) recognize that TEE, arterial lines, CVP and PA catheters may be placed for additional monitoring or diagnosis beyond that included in the base unit value for the anesthesia service and may be necessary for the performance of an anesthetic.
Lines, Blocks, TEE and Anesthesia Time

5. (continued)

- When these lines are placed or diagnostic studies performed AFTER anesthesia is induced, the time spent performing these procedures does not need to be deducted from the anesthesia time.
- However, if the service is conducted PRIOR TO induction of the anesthesia for a surgical procedure being performed by another provider, the line placement or TEE is still separately reportable, but should not be part of the anesthesia time. Deduct the time spent on placing from anesthesia time.
- Sedation for placement of the line does not qualify as an event that starts anesthesia time.

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Lines, Blocks, TEE and Anesthesia Time

6. Epidurals/blocks for postoperative pain are reported separately from an anesthesia service only if they are performed for post-operative pain care. If they were used as the primary anesthetic, not reportable.

- When these blocks meet the criteria to be reported separately from the anesthesia service, the time spent placing the epidural or block is handled in the same way as it is for TEE, arterial lines, CVP and PA catheters as described in [5] above.
POLL #3

- What tool do you use for selecting the anesthesia CPT code when you know the procedure CPT code?
  - 1. ASA CROSSWALK® book
  - 2. ASA CROSSWALK® loaded on computer
  - 3. Competing book-based product
  - 4. Competing computer-based product
  - 5. None, I don’t use a tool and do it manually.

2009 CROSSWALK®

- CROSSWALK®
  - Links procedure code to anesthesia code (00100-01999)
  - Alternate anesthesia codes are offered for instances where other factors influence code choice.
  - It is important to recognize that the listing of a CPT-4 procedure code with a CPT-4 anesthesia code does not limit or restrict the use of an alternate or unlisted anesthesia code.
  - The 2009 CROSSWALK® is to be used in conjunction with the 2009 AMA CPT-4 publication and the 2009 ASA Relative Value Guide®.
2009 CROSSWALK®

- Both the Relative Value Guide® and the CROSSWALK® are reviewed and updated annually.
- CROSSWALK® Review Process
  - New/Revised/Deleted CPT procedure codes
  - Codes in the same family are also reviewed
  - Each code is reviewed every 3 years in a rolling review process
  - Suggestions

CROSSWALK® Suggestions

- Must be received by June 1, 2009 to be reviewed.
  - Crosswalk® associates the procedure CPT code with the anesthesia CPT code based upon clinical reasons
  - The CROSSWALK® is not designed to be used as an economic instrument. Note that the base unit value listed is for the primary cross only.
When selecting an anesthesia code, typically consider the body area/system/organ being worked on.

Do not select code based on surgical approach unless there is a specific anesthesia code defining the approach.

- Cardiac endovascular repairs

Upper abdominal intraperitoneal procedures are those performed on the organs of the upper abdomen – spleen, pancreas, gallbladder, small intestine and colon until the sigmoid.

Lower abdominal intraperitoneal procedures are those performed on the sigmoid, rectum, uterus, tubes, ovaries, bladder, appendix and limited procedures at the appendicle/cecal junction.
Unlisted Procedure Codes

• Unlisted procedure codes can describe any number of surgical procedures not assigned a Category I or Category III CPT code

• When Category III codes sunset without transitioning to Category I, CPT often instructs that the procedure be reported with an unlisted code

• Many of the CROSSWALK® comments received for 2009 involved unlisted codes

2009 CROSSWALK® provides the following guidance for all unlisted procedure codes:

***UNLISTED CODES ARE NON-SPECIFIC. SELECT THE ANESTHESIA CODE THAT BEST CORRESPONDS TO THE SPECIFIC PROCEDURE PERFORMED***
Spinal Instrumentation

• 2008 CROSSWALK®
  – Primary procedure codes crossed to 00600, 00620, 00630
  – Add-on codes that describe the instrumentation component of the surgical procedure crossed to 00670

Spinal Instrumentation

• Received reports that this was creating difficulty when a payer required CPT procedure codes and would accept only one code

• 2009 CROSSWALK®
  – Code 00670 is provided as an alternate anesthesia code for the primary procedure
New Comments/Instructions

• Spinal Instrumentation
  – When 00670 was added as an alternate to a primary procedure code, the CROSSWALK® includes an instruction that:
    “Code 00670 is appropriate only if procedure is performed in conjunction with an add-on code indicating multi-level procedures or spinal instrumentation”

How to Order Your 2009 Relative Value Guide® and CROSSWALK®

• Online at http://www2.asahq.org/publications/

• By phone
(847) 825-5586
Poll #4 - Future Webinar Topics

Topics you would like ASA to cover in future webinars
• 1. ICD-10
• 2. Implementing PQRI
• 3. Medicare Conditions of Participation
• 4. Other

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Questions & Answers

If you would like to ask a live question over the phone, please press *1 on your telephone keypad now...

OR

You may enter your question in the box at the lower left corner of your screen and click on the “Send” button located next to it.

THANK YOU