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FEBRUARY 2016

PQRS UPDATE

For 2016, anesthesiologist must consider PQRS reporting options in order to avoid CMS-PQRS payment adjustment (reductions) in 2018. Practices should review the attached five measure specifications. These measures must be reported through a registry. The only claims based measure for anesthesiologist to report is #76: Prevention of Catheter-Related Bloodstream Infections.

The new measures are as follows:
#404: Anesthesiology Smoking Abstinence
#424: Perioperative Temperature Management
#426: Post-Anesthetic Transfer of Care Measure: Procedure Room to a Post Anesthesia Care Unit (PACU)
#427: Post-Anesthetic Transfer of Care Measure: Use of Checklist or Protocol for Direct Transfer of Care from Procedure Room.
#430: Prevention of Post-Operative Nausea and Vomiting (PONV) - Combination Therapy.

You may view a detailed summary of codes for New PQRS Measures on our website.

CMS stated in a recent email to PAR that if a practice is not able to report Measure #76 via claims, that the EP (eligible practitioner) is required to hire a registry for reporting the other applicable measures or a Qualified Clinical Data Registry (QCDR). The ASA had advocated on your behalf urging CMS to allow claims-based reporting for anesthesia measures.

View General PQRS FAQs.

According to ASA and AQI, they will be issuing guidance on reporting requirements in the upcoming months. The QCDR requirement remains the same; a provider must report on greater than 50% of the eligible cases for 9 measures covering 3 domains with 2 outcome measures. ASA/AQI is in the process of applying for recognition as a qualified registry in addition to their status as a QCDR approved registry.

Coding Corner: Changes, Revisions & Deletions

CPT is updated each year with new, revised and deleted codes. Below is a summary of recent changes that effect anesthesia and pain management providers.

Anesthesia Codes
No new ASA codes.

No changes to the base unit value of any ASA codes.

The Relative Value Guide (RVG) no longer contains position statements from the Committee of Economics. All Statements on standards and guidelines can now be reviewed on the ASA website .

Statements previously published in the RVG were amended in October 2015:
- Statement on transesophageal echocardiography
- Reporting postoperative pain procedure in conjunction with anesthesia

A new statement on distractions was released in October 2015.

New Nerve Block Codes
There are now codes for paravertebral injections and continuous catheter.

64461 Paravertebral block (PVB) (paraspinous block), thoracic; single injection site (includes imaging guidance, when performed)

64462 Paravertebral block (PVB) (paraspinous block), thoracic; second and any additional injection site(s) (includes imaging guidance, when performed) (List separately in addition to code for primary procedure)

64463 Paravertebral block (PVB) (paraspinous block), thoracic; continuous infusion by catheter (includes imaging guidance, when performed)

Code 64462 is used in conjunction with 64461, imaging is not separately reportable.

The medically unlikely edit for all three codes is 1, these codes can be reported once on a date of service.

Revised codes
95972 Electronic analysis of implanted neurostimulator pulse generator system is no longer a time based code. Programming for up to 1 hour has been removed from the code description.

Deleted Codes
Code 95973 Electronic analysis of implanted neurostimulator pulse generator system, each additional 30 minutes after first hour has been deleted. This add on code was previously reported with code 95972.

Code 64412 Injection, anesthetic agent; spinal accessory nerve has been deleted in CPT due to low utilization. CPT parenthetical notes now instructs the coding of this injection to be reported with 64999, unlisted nervous system procedure code.

Evaluation and Management New Codes
99415 Prolonged clinical staff service during an evaluation and management service in the office or outpatient setting, direct patient contact with physicians supervision; first hour

99416 Each additional 30 minutes

These time based evaluation and management are reported in conjunction with office or outpatient E/M codes when that service is beyond the typical E/M service time. These codes require face to face time of clinical staff with physician or other qualified health care professional supervision. Services less than 45 minutes are not reportable, as the time is included in the office or outpatient E/M service. Prolonged services are listed in the OIG FY 2016 work plan.

Chronic Pain Procedures Compliance

CPT 2016 coding instructions
There are several coding notations within CPT 2016 that have been added for denervation coding guidance. Destruction by neurolytic agent, paravertebral facet joint nerves, single facet joint codes 64633-64636 have added parenthetical notes within CPT. Coding instructions indicate to code for each facet joint that is denervated not the number of nerves treated. Codes 64633-64636 are not reported for non-thermal denervation including chemical, low grade thermal energy of <80 degrees Celsius. These codes cannot be reported for pulsed radiofrequency, instead it should be reported with unlisted code 64999. These detailed instructions within CPT implies providers should document the degrees Celsius that is being used for the procedures.

Code 64640 destruction by neurolytic agent; other peripheral nerve or branch is to be reported for the destruction by neurolytic agent, individual nerves, of the sacroiliac joint. These new instructions correlate with a CPT assistant article of June 2012 which states 64640 should be reported four times for peripheral nerve destruction at L5, S1, S2, and S3.

The RVG has added coding instructions for facet joint denervation that correlates with the CPT revision. In addition the RVG includes facet joint injections 64490-64495. It states to report the number of facet joints injected, not the number of nerves.

Anesthesia Services Documentation Compliance
The ASA Relative Value Guide has New/Revised Instructions for code assignment in several areas.

Anesthesia for intracranial procedure in the sitting position ASA code 00218 would be reported instead of another anesthesia code. This code is a 13 base unit code, higher than most intracranial procedure codes. Patient positioning must be documented on the anesthesia record to report this higher base unit code.

The insert of cardioverter-defibrillators includes testing of the defibrillator are reported with ASA code 00534 (7 base units). The RVG states to report anesthesia management with code 00530 (4 base units) if the defibrillator functions are not tested during insert. Documentation on the anesthesia record must include the testing of the ICD during the insert to report ASA code 00534. Electrophysiological procedures including radiofrequency ablation are to be reported as ASA code 00537 (10 base units).

Documentation of Image Guidance Procedures

Imaging Guidance
CPT has continually increases the number of procedure codes where imaging guidance or imaging supervision and interpretation is a component of the procedure. Guidelines were added to CPT in 2016 to address this trend in code changes. CPT states 'When imaging guidance or imaging supervision and interpretation is included in a surgical procedure', radiology guidelines for image documentation and report will apply. The radiology guidelines now state 'A written report signed by the interpreting individual should be considered an integral part of the radiologic procedure or interpretation'. CPT has added the term 'images' to 'refer to those acquired in either analog or digital manner'.

An increasing number of services include imaging such as the new paravertebral blocks codes 64461-64463. Imaging guidance is not separately reportable when it is a component of the procedure. When imaging is not a component, it may be reported separately following radiology requirements.

Ultrasound guidance procedures require permanently recorded images, a documented description of the localization, separately or within the report of the procedure for which the guidance is used.

FDA & Washington Alerts

ASA Advocates on Payment and Quality Matters within CMS Final Rule for the 2016 Medicare Physician Fee Schedule. Read article.

CMS Corrections to the 2016 Fee Schedule

Please note CMS has issued corrections to the 2016 fee schedule including a slight reduction to the Anesthesia Conversion Factor for New England.

Anesthesia Conversion Factor				
Locality	State	PAR AMT	NON PAR	LIMITING
03	Southern Maine	$21.53	$20.45	$23.52
99	Rest of Maine	$21.23	$20.17	$23.19
01	Metro Boston	$22.32	$21.20	$24.38
99	Rest of Massachusetts	$21.99	$20.89	$24.02
40	New Hampshire	$22.02	$20.92	$24.06
50	Vermont	$21.57	$20.49	$23.57

01	Rhode Island	$22.22	$21.11	$24.28
Procedure Code 01953				
Locality	State	PAR AMT	NON PAR	LIMITING
03	Southern Maine	$21.53	$20.45	$23.52
99	Rest of Maine	$21.23	$20.17	$23.19
01	Metro Boston	$22.32	$21.20	$24.38
99	Rest of Massachusetts	$21.99	$20.89	$24.02
40	New Hampshire	$22.02	$20.92	$24.06
50	Vermont	$21.57	$20.49	$23.57
01	Rhode Island	$22.22	$21.11	$24.28
Procedure Code 01996				
Locality	State	PAR AMT	NON PAR	LIMITING
03	Southern Maine	$64.59	$61.36	$70.56
99	Rest of Maine	$63.69	$60.51	$69.58
01	Metro Boston	$66.96	$63.61	$73.15
99	Rest of Massachusetts	$65.97	$62.67	$72.07
40	New Hampshire	$66.06	$62.76	$72.17
50	Vermont	$64.71	$61.47	$70.70
01	Rhode Island	$66.66	$63.33	$72.83

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