Physician's Accounts Receivable Management, LLC
181 Wells Avenue Suite 302 • Newton, MA 02459-3210
Phone: 781-972-7100 • Fax: 781-449-3970

PQRS CHANGES 2016

CMS has retired PQRS ***#193: Perioperative Temperature Management*** and removed claim based reporting for PQRS ***#44: CABG Preoperative Beta Blocker***. These changes leave only PQRS measure ***#76: Prevention of Catheter-Related Bloodstream Infections***. CMS has new PQRS measures, however they can only be reported via registry. One of the new measures is a revised version measure #193 -again this can only be reported via registry.

Practices are urged to log onto ASA PQRS 2016 Notice to better understand how their practice will be impacted with these changes. Once the final CMS ruling is announced we will provide practices additional information.

PQRS 2016 Notice

CMS ANESTHESIA 2016 CONVERSION FACTORS

Effective January 1, 2016 the national average conversion factor will be decreased to $22.44. Below is the locality-adjusted Anesthesia conversion factors as a result of the CY 2016.

Locality	Locality Name	National Anes CF of $22.4426
00	Alabama	21.14
01	Alaska**	31.10
00	Arizona	22.04
13	Arkansas	20.72
26	Anaheim/Santa Ana, CA	23.75
18	Los Angeles, CA	23.75
03	Marin/Napa/Solano, CA	23.87
07	Oakland/Berkeley, CA	23.76
05	San Francisco, CA	24.56
06	San Mateo, CA	24.44
09	Santa Clara, CA	24.50
17	Ventura, CA	23.42
99	Rest of California	22.77

99	Rest of California	22.77
01	Colorado	22.61
00	Connecticut	23.63
01	DC + MD/VA Suburbs	24.48
01	Delaware	22.88
03	Fort Lauderdale, FL	23.26
04	Miami, FL	24.42
99	Rest of Florida	22.37
01	Atlanta, GA	22.37
99	Rest of Georgia	21.51
01	Hawaii/Guam	22.60
00	Idaho	20.67
16	Chicago, IL	24.23
12	East St. Louis, IL	23.12
15	Suburban Chicago, IL	23.72
99	Rest of Illinois	21.99
00	Indiana	21.12
00	Iowa	20.76
00	Kansas	21.00
00	Kentucky	21.21
01	New Orleans, LA	22.71
99	Rest of Louisiana	21.89
03	Southern Maine	21.68
99	Rest of Maine	21.08
01	Baltimore/Surr. Cntys, MD	23.45
99	Rest of Maryland	22.80
01	Metropolitan Boston	22.84
99	Rest of Massachusetts	22.47
01	Detroit, MI	22.83
99	Rest of Michigan	21.80
00	Minnesota	21.50
00	Mississippi	20.69
02	Metropolitan Kansas City, MO	22.00
01	Metropolitan St Louis, MO	22.08
99	Rest of Missouri	20.96
01	Montana ***	21.99
00	Nebraska	20.64

00	Nevada ***	22.70
40	New Hampshire	22.49
01	Northern NJ	23.95
99	Rest of New Jersey	23.47
05	New Mexico	22.09
01	Manhattan, NY	25.01
02	NYC Suburbs/Long I., NY	25.67
03	Poughkpsie/N NYC Suburbs, NY	23.55
04	Queens, NY	25.69
99	Rest of New York	21.67
00	North Carolina	21.48
01	North Dakota ***	21.24
00	Ohio	21.84
00	Oklahoma	21.05
01	Portland, OR	22.32
99	Rest of Oregon	21.70
01	Metropolitan Philadelphia, PA	23.49
99	Rest of Pennsylvania	22.00
20	Puerto Rico	18.86
01	Rhode Island	22.70
01	South Carolina	21.31
02	South Dakota***	20.84
35	Tennessee	20.89
31	Austin, TX	22.17
20	Beaumont, TX	21.78
09	Brazoria, TX	22.67
11	Dallas, TX	22.48
28	Fort Worth, TX	22.20
15	Galveston, TX	22.76
18	Houston, TX	22.73
99	Rest of Texas	21.72
09	Utah	21.80
50	Vermont	21.70
00	Virginia	21.99
50	Virgin Islands	21.85
02	Seattle (King Cnty), WA	22.79

99	Rest of Washington	21.72
16	West Virginia	21.52
00	Wisconsin	21.41
21	Wyoming ***	22.48

ICD-10: FLEXIBILITY GUIDANCE STATEMENT

On October 1, 2015, ICD-10 was successfully implemented across the country. The Centers for Medicare and Medicaid services with the AMA together issued a joint announcement, *The Flexibility Guidance Statement for Medicare providers*.

The statement indicates that for the first year after implementation, claims will not be denied due to lack of specificity. Claims submitted with valid ICD-10 codes will be processed and not a cause for audit as long as the diagnosis code is in the correct family code.

A family of codes are a set of codes that describe a disease with or without additional conditions. For example, **K80** is the family code for cholelithiasis which contains over thirty codes. The following are some examples of codes within the same family:
K80.10 Calculus of gallbladder with chronic cholecystitis without obstruction
K80.33 Calculus of bile duct with acute cholangitis with obstruction
K80.34 Calculus of bile duct with chronic cholangitis without obstruction
K80.12 Calculus of gallbladder with acute and chronic cholecystitis without

It is important to note that these policies will require no greater specificity in ICD-10 than was required in ICD-9, with the exception of laterality, which does not exist in ICD-9. LCD's and NCD's that contain ICD-10 codes for the right side, left side or bilateral do not allow for unspecified side.

The local and national coverage determinations policies are in effect and providers must still meet diagnosis requirements to support the medical necessity of the service provided. National government services medical policies can be reviewed for detailed diagnosis requirements.

View NGS medical policies for detailed diagnosis requirements

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2016 OIG WORK PLAN

Judith Jurin Semo, legal consultant to many anesthesia practices, has graciously allowed us to share with you her summary of the 2016 OIG Work Plan. Anesthesia was specifically named twice in the work plan and group compliance officers should review the work plan in determining their 2016 audit and monitoring plans.

November 2, 2015 the OIG issued its FY 2016 Work Plan. Of note for anesthesiologists:

1. Anesthesia now appears twice on the Work Plan.

a. The OIG continues to list "Anesthesia services - payments for personally performed services" as a focus area. FY 2016 marks the fourth consecutive year in which this topic is included in the OIG annual work plan. The OIG is looking at whether cases billed using the AA modifier (personally performed) met the requirements for the AA modifier, or if they should have been billed as QK (medical direction).

b. In addition, the OIG lists a new area: "Anesthesia services-non-covered Services." The explanation of the new focus area states:

We will review Medicare Part B claims for anesthesia services to determine whether they were supported in accordance with Medicare requirements. Specifically, we will review anesthesia services to determine whether the beneficiary had a related Medicare service. Medicare will not pay for items or services that are not "reasonable and necessary."

Anesthesiologists should be careful to bill only for anesthesia services that are supported by medical necessity.

2. The OIG also lists the following new areas that may be of interest to anesthesiologists:

a. Physicians referring/ordering Medicare services and supplies, to determine if the physicians are legally eligible to order such services and supplies.

b. Imaging services - payments for practice expenses, to determine if payments for imaging services reflect the expenses incurred and if the utilization rates reflect industry practices. Anesthesiologists who bill for imaging services in connection with regional anesthesia or pain blocks will be interested in this focus area.

c. Prolonged services - reasonableness of services, relating to prolonged E&M services and if they were billed in accordance with Medicare requirements.

d. ASC - quality oversight. The OIG notes that the OIG previously found problems in Medicare's oversight system for some ASCs and little public information on the quality of ASCs. The OIG notes that Medicare sets minimum health and safety requirements for ASCs through the conditions for coverage.

3. Several other areas relating to the Medicare program also may be of interest:

a. Use of EHRs to support care coordination through ACOs: The OIG will review the extent to which providers participating in ACOs in the Medicare Shared Savings Program use EHRs to exchange health information to achieve care coordination goals.

b. ACOs - Strategies and Promising Practices: The OIG will look at ACOs that participate in the Medicare Shared Savings Program to describe their performance on quality measures and costs savings and describe the characteristics of those ACOs

that performed well on both items.

c. CMS management of ICD-10 implementation: The OIG will review CMS's early management of the implementation of ICD-10, including the assistance and guidance that CMS and the MACs have provided to hospitals and physicians and how ICD-10 is affecting claims processing, including claims resubmissions, appeals, and medical reviews.

d. Medicare incentive payments for adopting EHRs: The OIG will review these payments to identify payments to providers that should not have received incentive payments, meaning those who did not meet selected meaningful use criteria.

View Full OIG Work Plan

Carrier Notifications Regarding TAP Blocks

Neighborhood Health Plan and Vermont Medicaid consider TAP blocks a non-covered service. They will not reimburse providers for the following CPT procedure codes: 64486, 64487, 64488 and 64489.

64486 Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by injection(s) (includes imaging guidance, when performed)

64487 Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) unilateral; by continuous infusion(s) (includes imaging guidance, when performed)

64488 Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral; by injections (includes imaging guidance, when performed)

64489 Transversus abdominis plane (TAP) block (abdominal plane block, rectus sheath block) bilateral; by continuous infusions (includes imaging guidance, when performed)

PAIN MANAGEMENT: POLICY L35936

National Government Services has revised the ICD-10 code to use for facet arthropathy from M12.9 to M12.88 in policy L35936 for chronic pain procedures. Code ***M12.88 other specific arthropathies, not elsewhere classified, other specified site*** is nonspecific. Guidelines indicate codes should be reported to the highest level of specificity.

View Policy L35936

Code M12.88 does not support the medical necessity requirement for facet joint and ablative treatments for other carriers such as Untied Healthcare and Harvard Pilgrim.

View United Healthcare's Medical Policy

View Harvard Pilgrim's Medical Policy

PAIN MANAGEMENT: GLOBAL PERIOD

Global surgical package includes pre-operative, intra-operative and post-operative services for a procedure normally provided before, during and after a procedure. The fee schedule amount includes related evaluation and management services to the procedure during the global period. These evaluation and management services during the global period are not separately payable. Services that are unrelated to the surgical package require appending of the applicable modifiers to the CPT code for compliant claim submission during the global period. The following pain clinic procedures contain a 10 day global surgical package; evaluation and management services related to these procedures should not be submitted for separate billing within the global period.

64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint
64630	Destruction by neurolytic agent; pudendal nerve
64640	Destruction by neurolytic agent; other peripheral nerve or branch
63650	Percutaneous implantation of neurostimulator electrode array, epidural

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Par Management wishes you and your family a warm & happy holiday season!

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PAR Management, LLC | Newsletter@parmanage.com | 781-972-7100 | parmanage.com