This month’s edition of Chargemaster Corner reviews a few topics discussed in April’s publication. We received several comments and questions and this month’s edition will combine some of last month’s “old” topics with some new ones.

Also we would like to extend a welcome to our many new subscribers who have requested to be added to the distribution list during this past month.

Feel free to e-mail comments and questions and interesting challenges your facility is encountering. See you next month!!

Nerve Injections Revisited
We’d like to revisit the article published in the April’s edition of Chargemaster Corner entitled Nerve Blocks Performed with Surgical Procedures. E-mails with cited NCCI references from our readers rendered a different opinion than discussed in the April article. The official NCCI edit guidelines as well as CPT Assistant references sent in support of those “differing opinions” will be reviewed, but also seemingly support last month’s article, summarized as stating a facility may report pre- and post-operative nerve block injections which were provided “outside” the time reported for delivering anesthesia services (CPT 0010-0999) and provided by a CRNA or anesthesiologist. Postoperative pain management services are generally provided by the surgeon who is reimbursed under a global payment policy related to the procedure and shall not be reported by the anesthesia practitioner unless separate, medically necessary services are required that cannot be rendered by the surgeon. The surgeon is responsible to document in the medical record the reason care is being referred to the anesthesia practitioner. Please note that the “reason care is referred” has not been clarified by CMS.

It is often identified that coding guidelines issued by recognized organizations and official coding guidelines differ when it comes to modifier as well as CPT code assignments. However, Chapter 2, NCCI (National Correct Coding Initiative Policy Manual) supports CPT Assistant references. NCCI Anesthesia edit guidelines state: CPT codes 64400-64530 (Nerve blocks) may be reported on the date of surgery if performed for postoperative pain management rather than as the means for providing the regional block for the surgical procedure. Pain management performed by an anesthesia practitioner after the postoperative anesthesia care period terminates may be separately reportable. However, postoperative pain management by the physician performing a surgical procedure is not separately reportable by that physician. Postoperative pain management is included in the global surgical package. Modifier 59 may be reported to indicate that the injection was performed for postoperative pain management, and a procedure note should be included in the medical record.

CPT Assistant states “When general anesthesia is administered and these injections are performed to provide postoperative analgesia, they are separate and distinct services and are reported in addition to the anesthesia code. Whether the block procedure (insertion of catheter; injection of narcotic or local anesthetic agent) occurs preoperatively, postoperatively, or during the procedure is immaterial.” October, 2001.

“We have two official coding guidelines essentially providing identical guidance,” states John Arno, RT, (R), ARRT, CPC-A, MPA. “This supports Ingenix’ comments that when pre- and post-nerve block procedures are performed, the codes can be reported with modifier 59 as appropriate. It is not often the cited coding guidelines recommend the use of the controversial modifier 59, but in this specific instance they do! Of course, that does not side step the necessary documentation requirements previously discussed.” Now let’s take it one step further. Another official coding reference is the AHA’s Coding Clinic for HCPCS. The AHA Central Office serves as the only official clearinghouse for information on the proper use of Level I HCPCS (CPT-4 codes) for hospital providers and certain Level II HCPCS codes for hospitals, physicians and other health professionals. See: www.ahacentraloffice.com/.

“One of our clients submitted the following question to AHA: Question—“Is the use of these codes (CPT 62318, 64416, 64448, 64413, 64415, 64417, 64445, 64447 and 64483) as injections for post-op pain control allowed for OPPS for use on surgical patients? Injections are given by the anesthesiologist and not the surgeon performing the procedure?” AHA replied “For OPPS reporting, postoperative pain management is typically not separately reportable. Any postoperative recovery services related to the surgery or procedure are considered inherent to the surgical service provided, and therefore, are not separately reported. If the pain management provided is unrelated to the procedure performed, it would be appropriate to report the pain management provided.” John Arno continues, “Based on the AHA’s statement it would appear post-operative nerve blocks would not be reportable, but CPT
Assistant and NCCI edits support the use of these CPT codes. The provider must review all references and decide what guidelines the facility will follow. We all know that IM or IV push injections for pain management in the recovery room are considered part of the surgical procedure and not separately reportable. However, these nerve block injections require the professional skill of anesthesia or other professional services.”

Glenda Schuler, RHIT, CPC, CPC-H relates the following: “Many facilities perform PICC or central line insertions, placed in the pre-op holding area or even in the recovery room. Anesthesia services often are the professional performing this procedure, allowing ease in delivery of post-procedure long-term therapeutic medication administration. These procedures would definitely be separately reportable; they are distinct and unique from the planned surgical procedure. Nerve blocks can be likened to this scenario and they are distinct and unique from the planned surgical procedure. Nerve blocks can be likened to this scenario and separately reportable; that is, unless the facility elects to apply the AHA’s guidelines or has a different interpretation than the references discussed above. Being cautious and conservative is certainly an honorable attribute Ingenix respects when discussing other controversial subjects with clients and healthcare professionals. But it was felt that another re-visit of last month’s article, Chargemaster Corner would help provide additional clarification. Thanks to our readers for your comments and questions!!

**Curiosity Is Best** when you use it to review the new Category III CPT codes available for reporting July 1, 2011. The American Medical Association posted fourteen new surgical and procedure CPT codes which will soon be added to the chargemaster or assigned by HIM coding specialists. Next month’s Chargemaster Corner will go into more detail about each of these new CPT codes, but if you would like to take a sneak peak, the following link will take you directly to the [Chargemaster Consulting](http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt/category-iii-codes.page)

**New CPT Codes on The Horizon**

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No NCCI edit exists, however, if 90472 is reported along with G0008-G0010. Penny Allison, RN, BNS, Director of Chargemaster Consulting advises “If the facility would consider the Influenza, Pneumococcal or Hepatitis B administration as the initial immunization, all subsequent administrations would be appropriate to report with CPT 90472, Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure). For instance, should the patient receive a Hep B and a tetanus toxoid administration, G001059 and 90471 would be one option. Modifier 59 has to be reported with the Hep B administration to bypass current NCCI edits.” Penny continues, “Should the facility consider the Hep B administration as the initial, G0010, and report 90472 for the tetanus toxoid as the second administration, there is no NCCI edit generated.”

Review of CPT instructions however is slightly different. Parenthetical statement beneath CPT 90472 indicates it is an add-on code, reportable with CPT 90471 or CPT 90473. “CPT reporting instructions, however, do not take into consideration Medicare’s specific reporting directives,” states Joe Martinez, CPC, Senior Healthcare Consultant. “If Medicare requires a different code we have to review the NCCI edits impacting these specific codes and default to Medicare’s reporting directives. CPT and HCPCS codes do not present a hierarchy nor differentiate between vaccine products, defining which vaccine is to be considered as “first” and which vaccine would be reported with an add-on code.” Therefore to avoid the required modifier 59 when reporting G0008-G0010 with CPT 90471, facilities should explore the option of reporting HCPCS G0008-G0010 with CPT 90472. Net reimbursement will not be impacted by either option the facility elects to utilize when reporting multiple immunization administration scenarios.
Let us know your facility’s reporting practices. Have you elected to use modifier 59 with 90471 and G0008-G0010? If you report 90472 without 90471 are your claims being returned? Just more to think about!

Reminders…..as if it is necessary
We frequently read of sizeable amounts of money the RAC program and its auditing programs are saving the Medicare program. To keep abreast of new audit initiatives as well as audit findings in your region, each MAC’s website contains regional CERT claims error data. Statistics, FAQ links, references and resources are available for providers to help recognize reporting issues identified with the regional claim audits. Based on the review of the provided medical records, claim errors are categorized into five different error categories. 1) No documentation—Claims are placed into this category when the provider fails to respond to repeated attempts to obtain the medical records in support of the claim. 2) Insufficient documentation—This category is used when the medical documentation submitted does not include pertinent patient facts (e.g. the patient’s overall condition, diagnosis, and extent of services performed), 3) Medically unnecessary service—Claims are placed into this category when claim review staff identify enough documentation in the medical records submitted to make an informed decision that the services billed were not medically necessary based on Medicare coverage policies, 4) Incorrect coding—This category is used when providers submit medical documentation that support a lower or higher code than the code submitted, and 5) Other—Represents claims that do not fit into any of the other categories (e.g. service not rendered, duplicate payment error, not covered or unallowable service).

Facilities must continually be vigilant in their auditing and documentation improvement programs to avoid any potential payback scenarios as a result of one of the above giveb issues. Don’t feel overwhelmed; take one day at a time. Ingenix will certainly be able to supplement your staffing, auditing, coding needs to prepare or respond to RAC, CERT and other government agency requests.

We hope you enjoy receiving the Chargemaster Corner from Ingenix. Each month Ingenix will circulate this newsletter via e-mail to those interested parties who have provided contact information either via e-mail request or who have completed an informational form when attending a number of educational seminars conducted nationwide. Please share this e-mail with your co-workers and encourage them to contact Ingenix via Chargemaster.corner@gmail.com. Contact information will not be shared with any other organization and used only for means of distributing this monthly newsletter. For direct contact concerning receipt of this newsletter, please e-mail your comments to the above noted e-mail address. Thank you for your interest in this monthly chargemaster newsletter and hope you find it helpful.

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