Part B Insider (Multispecialty) Coding Alert

Correct Coding Guidelines: CCI Policy Manual Reveals When Postop Pain Treatment Can Be Billed Separately From Surgery

Plus: Find out the details behind one confusing MUE edit.

Stumped by why a medically unlikely edit would have a limit of zero units? CMS has your answer, with new policies that help you determine why certain edits exist.

Although we mostly think about lists of coding bundles when we discuss the Correct Coding Initiative (CCI), there is another side to national bundling rules--the National Correct Coding Initiative Policy Manual. And thanks to a Jan. 2012 update, you should peruse the manual to determine what's changed this year. We've got the lowdown on a few important changes that are sure to affect the way you code your services, thanks to coder **Kristi Stumpf, MCS-P, CPC, COSC, ACS-OR**, owner of Precision Auditing and Coding, and senior orthopaedic coder and auditor with The Coding Network, who broke down the changes for the Insider.

Background: The Policy Manual is updated annually and offers the rationale for various CCI edits. For instance, chapter two of the manual describes the services included in anesthesia coding, and notes, "It is standard medical practice for an anesthesia practitioner to perform a patient examination and evaluation prior to surgery. This is considered part of the anesthesia service and is included in the base unit value of the anesthesia code." Because of this passage, coders shouldn't be surprised to find E/M services bundled into many anesthesia codes.

CMS Discusses MUE Value of '0'

Medically unlikely edits (MUEs) are still relatively new, so many coders might scratch their heads at some aspects of these edits--particularly when a service has a limit of '0.' If you're wondering why a service would be listed at all if the limit is zero, the 2012 update to the manual finally offers some answers.

"The rationale for such values include but are not limited to: discontinued manufacture of drug, non-FDA approved compounded drug, practitioner MUE values for oral anti-neoplastic, oral anti-emetic, and oral immune suppressive drugs which should be billed to the DME MACs, and outpatient hospital MUE values for inhalation drugs which should be billed to the DME MACs," the manual notes.

In other words, CMS wants the code listed in the CCI edits, but wants to remind coders that it won't be reimbursed.

CCI Clarifies Recent Substance Abuse Assessment

Last spring, we told you about how the CCI began bundling alcohol and/or substance abuse assessment codes G0396 and G0397 into most E/M codes (99201-99239). Now the manual explains the rationale behind those edits.

"If the E/M, psychiatric diagnostic, or psychotherapy service would normally include assessment and/or intervention of alcohol or substance abuse based on the patient's clinical presentation, HCPCS G0396 or G0397 should not be additionally reported," the manual states.

Because these edits can be separate using a modifier, the Policy Manual breaks down the appropriate use of one when necessary. "If a physician reports either of these G codes with an E/M, psychiatric diagnostic, or psychotherapy code utilizing an NCCI-associated modifier, the physician is certifying that the G code service is a distinct and separate service performed during a separate time period (not necessarily a separate patient encounter) than the E&M... and is a service that is not included in the E&M," the CCI manual states.

Dig Into Postop Pain Guidelines

As many coders are aware, surgeons are responsible for treating postoperative pain, and those services are typically bundled into the charge for the surgery itself. However, if an anesthesiologist is called to administer postop pain management, it can be payable--if you know the guidelines set forth in the Policy Manual.

"The actual or anticipated postoperative pain must be severe enough to require treatment by techniques beyond the experience of the operating physician," the manual notes. "For example, the operating physician may request that the anesthesia practitioner administer an epidural or nerve block to treat actual or anticipated postoperative pain."

The anesthesiologist can administer the epidural or nerve block preoperatively, intraoperatively, or postoperatively -- "however, if the epidural or nerve block is administered preoperatively or intraoperatively, the epidural or nerve block is separately reportable by the anesthesia practitioner only if the epidural or nerve block is not utilized for intraoperative pain management," the manual notes. "An epidural or nerve block that provides intraoperative pain management even if it also provides postoperative pain management is included in the 0XXXX anesthesia code and is not separately reportable. The anesthesia practitioner may report modifier 59 to indicate that the epidural or nerve block was performed for postoperative pain management, not intraoperative pain management, and a procedure note should be included in the medical record."

If the surgeon asks the anesthesiologist to perform pain management services after the postoperative anesthesia care period ends, the anesthesia practitioner should report it separately using modifier 59.

Don't Double-Dip Arthrocentesis Payment

In many cases, a surgeon will perform an arthroscopic or open joint procedure during which he will extract fluid from the joint (arthrocentesis). Although some physicians attempt to collect separately for both the joint surgery and the arthrocentesis, you can kiss such pay goodbye, the Policy Manual indicates.

"Arthrocentesis procedures (e.g., CPT® codes 20600, 20605, 20610) should not be reported separately with an open or arthroscopic joint procedure when performed on the same joint," the manual states. "However, if an arthrocentesis procedure is performed on one joint and an open or arthroscopic procedure is performed on a different joint, the arthrocentesis procedure may be reported separately."

Consider Imaging Bundled Into These Chest Procedures

When it comes to emergency endotracheal intubation procedures (31500), Swan-Ganz catheter insertions (93503), and chest tube insertions (32422, 32550, 32551), your physician is most likely accustomed to performing a post-procedural x-ray to determine that the tubes are in the correct position. However, because CMS considers that imaging to be typically associated with the procedure, the CCI has included the imaging payment into the RVUs for the insertions.

"A chest radiologic examination CPT® code (e.g., 71010, 71020) should not be reported separately for this radiologic examination," the manual says regarding these post-procedure x-rays.

To read the complete updated Policy Manual, visit www.cms.gov/NationalCorrectCodInitEd.