2011 CODE CHANGES FOR ANESTHESIA & PAIN MGMT

Presented by

Deena Andrews, CPC

Coding Department Manager

Anesthesia Business Consultants, LLC

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ANESTHESIA CODING UPDATES

- ➢ **ANESTHESIA CODES**
  - No revisions, deletions or additions.
  - No base value changes.
  - Most significant change is the statement added in the ASA RVG book regarding anesthetic care during minor interventional pain procedures for <u>adults</u> – "Anesthesia Care Not Typically Required"
    - This means your documentation will have to support medical necessity for these services
      - » Conditions should exist which make skilled anesthesia care necessary, such as major co-morbidities and mental or psychological impediments to cooperation

- ➢ **ANESTHESIA CROSSWALKS**
  - No pertinent changes other than the aforementioned anesthesia for minor pain.

NERVE BLOCK CODE UPDATES

➢ **FACET INJECTIONS - 2010**

- 2010 CPT issued facet codes 64490 through 64495

- Limited the number of billable levels to only 3 (unilateral or bilateral)

- Imaging guidance became a bundled component of the codes, but was still a REQUIREMENT, or codes from range 20550-20553 were to be reported instead.

- Instructed to report 64493 (lumbar facet) for T12-L1 injection.

- Issued Category III codes (0213T through 0218T) for facets performed under ultrasound guidance.

➢ **FACET INJECTIONS - 2011 CHANGES:**

- If no imaging guidance is used, you'll report 20552 or 20553 (TPI). 20550 (tendon/ligament inj) will no longer be used.

- 64490 (thoracic facet) will be used for T12-L1 injection.

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NERVE BLOCK CODE UPDATES

➢ **TRANSFORAMINAL EPIDURAL INJECTIONS - 2010**
- 2010 CPT: 64479 through 64484
- Levels were billed 64479 or 64483 for first injection, then one add-on code for each additional level (unilateral or bilateral)
- Imaging guidance was separately reportable
- Instructed to report 64483 (lumbar TFESI) for T12-L1 injection
- July 2010: Issued Category III codes (0228T through 0231T) for TFESI performed under ultrasound guidance

➢ **TRANSFORAMINAL EPIDURAL INJECTIONS - 2011 CHANGES:**
- Imaging guidance is now a bundled component of the codes, but is still a REQUIREMENT.
- Instructed to report 64479 (thoracic TFESI) for T12-L1 injection

NEW E/M CODES FOR OBSERVATION CARE

➢ 99224 <u>Subsequent</u> Observation Care, per day, for the e/m of a patient, which requires at least 2 of these 3 components:
- Problem focused interval history
- Problem focused examination
- Straight-forward or low medical decision-making

➢ 99225 <u>Subsequent</u> Observation Care, per day, for the e/m of a patient, which requires at least 2 of these 3 components:
- Expanded problem focused interval history
- Expanded problem focused examination
- Moderate medical decision-making

➢ 99226 <u>Subsequent</u> Observation Care, per day, for the e/m of a patient, which requires at least 2 of these 3 components:
- Detailed interval history
- Detailed examination
- High medical decision-making

TAKE-AWAY POINTS

➢ **USE OF NEW OBSERVATION CODES**

  ▪ Per the AMA, these codes are to be reported by both the physician who initiates the observation care & any other doctor who evaluates the patient.

  ▪ They could become an alternative to bill when a physician provides a consultation service to an observation patient, but Medicare policy currently instructs to use outpatient E/M codes (99201-99215) for this when the provider did not initiate the observation care.

➢ **SUPERBILL/CHARGE TICKET UPDATES**

  ▪ If you will be performing facets or transforaminals under ultrasound guidance, make sure the 'new' category III codes are added to your charge tickets.

  ▪ If you will be performing subsequent observation care visits, make sure the new codes are added to your charge tickets.

➢ **CONTRACT NEGOTIATIONS**

  ▪ In 2010, new facet codes were issued, which allowed for payment negotiations & revised RVUs. For 2011, transforaminal codes are just getting revised definitions. The 2011 Physician Fee Schedule has not included imaging guidance in the RVUs, so be sure to make note of this during negotiations.

PQRS and Other Forms of Payment for "Value"

Karin Bierstein, JD, MPH

Vice President for Strategic Planning & Practice Affairs,
Anesthesia Business Consultants, LLC

**ABC Webinar
December 10, 2010**

But First:

- ## No SGR cuts in January!!!
  - Senate passed the *Medicare and Medicaid Extenders Act* Wednesday evening
  - House of Representatives did the same on Thursday morning

- ## Medicare payments will remain at present levels
  - through December 31, 2011

- ## Cost: $15-$19 billion over 10 years

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20 Minutes

1. Physician Quality Reporting <u>System</u>

2. Accountable Care Organizations (ACOs)

3. Medicare's Value-Based Purchasing Initiative

4. Incentive Payments for Electronic Health Records (EHRs)

1. PHYSICIAN QUALITY REPORTING SYSTEM

– What did the Patient Protection and Affordable Care Act ("PPACA," "ACA") and Fee Schedule Rule change?

- The name
    – "System" implies more permanence than "initiative"
    – Sufficient to report on 50% (was 80%) of eligible cases
        » Bonus based on 6 or 12 month period of "satisfactory" reporting

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PQRS Bonus Will Decrease & Turn Negative

- 2010   2.0%
- 2011   1.0%
- 2012   0.5%
- 2013   0.5%
- 2014   0.5%
- 2015   –1.5%
- 2016 …   –2.0%

Based on __all__ covered services, not just claims with reported measures

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More PQRS Changes

- ## New informal appeals process
  - – Request review by Quality Net Help Desk
    - within 90 days of feedback report release
  - – Written record only; written response
    - within 60 days
  - – Decision is final – no appeals

Same 3 Anesthesia Measures for 2011

- **#30**   Perioperative Care: Timely Administration of Prophylactic Parenteral Antibiotics

- **#76**   Prevention of Catheter-Related Bloodstream Infections: CVC Insertion Protocol

- **#193**   Perioperative Temperature Management

PQRS Measures for Pain Physicians

- Tobacco counseling measures **(#114**, **#115)** have been retired
- Preventive Care and Screening: Unhealthy Alcohol Use – Screening **(#173**)
- Documentation of Current Medications in the Medical Record **(#130)**
  – "Percentage of patients aged 18 years and older with a list of current medications (includes prescription, over-the-counter, herbals, vitamin/mineral [nutritional] supplements) documented by the provider, including drug name, dosage, frequency and route

and

Measure #124 HIT: Adoption/Use of Electronic Health Records (EHRs)

- Report at each o/p visit (99201-99215)

- No performance exclusions at all

- Documentation substantiates use of a certified, PQRS-qualified *or other acceptable EHR system, which means:*

  1. Ability to manage medication list
  2. Ability to manage a problem list
  3. Ability to enter lab results as searchable items
  4. Ability to meet basic privacy and security requirements

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CMS is Pushing Reporting through a _Registry_ or an _EHR_

- Claims-based reporting is disfavored because
  - it's difficult – many errors + no continuous audit function:
    - About 50% of anesthesiologists' and CRNAs' claims reported invalid Quality Data Codes in 1Q10.
    - 75% of audience on ASA webinar indicated they were participating and had received their incentive payment and/or feedback reports for 2009.
  - it doesn't require computer entry or generate a database automatically

Finally, An AIMS/EHR Fully Integrated With A Billing System

Announcement

ABC and iMDsoft Cooperate to Provide Complete AIMS and Anesthesia Billing Solution

MetaVision and F1RSTAnesthesia to be distributed jointly in the US

Same "Measure Applicability Validation" Test (MAV) if < 3 Measures

- Basic requirement = successfully report at least 3 measures
- If provider reports < 3 measures
  - Under the MAV process, CMS will apply a 2-part test
    - Clinical relation: "Measure clusters"
    - Minimum threshold of 15 eligible cases / 8 cases for 6-month reporting period

PQRS "MAV" Cont'd

- Only 2 anesthesia measure clusters
  - #76, CVC protocol, is not subject to MAV when reported by itself

- Can satisfy the MAV test by reporting:
  1. Measures #30 and #76, or
  2. Measures #193 and #76, or
  3. Measure #76 alone.

- Measures # 124, #130 and #173 explicitly excluded from MAV so reporting on 1 or 2 is enough

Reporting PQRS Measures Through a Registry

- 44 measures can *only* be reported through a registry – none relevant to anesthesia

- The anesthesia measures may optionally be reported through a registry

  – If there is a qualified registry available.

    - "A patient registry is an organized system that uses observational study methods to collect uniform [clinical and other] data from and evaluate specified outcomes for a defined population, who have a particular disease, condition or exposure, to serve predetermined scientific, clinical or policy purposes." (Glicklick & Dreyer)

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Registries for Anesthesiologists

NEW NEW NEW

- **OUTCOME™** (MGMA "Administerve" Partner) with MGMA)

- Can now accept Anesthesia Measures

- If you haven't participated in PQRI in 2010, you can still earn the bonus by sending your data to Outcome by January 31, 2011.

- Register for a weekly introductory webinar at www.outcome.org

The Anesthesia Quality Institute (AQI)

- Established as a separate corporation by ASA in 2009; will seek to qualify for PQRS in early 2011.

- Mission:

  – "Develop and maintain an ongoing registry of case data that helps anesthesiologists assess and improve patient care. Organize the registry so that anesthesiology practice groups desire to submit their case information, and so that individual anesthesiologists, practice groups, researchers, and professional societies find the data useful for improving the quality of care."

AQI Cont'd

- ***National Anesthesia Clinical Outcomes Registry (NACOR)***

- A database designed and managed by the profession to document participants' performance metrics and outcomes against benchmark data

- 46 practices are already reporting their data, or have at least signed contracts.

Another Bonus under the PQRS

- 2011-2014
- 0.5% of Medicare allowed charges
- if MD successfully reports PQRS measures, *and*
- participates in a Maintenance of Certification program required by a recognized medical board – e.g., ABA's **MOCA**
  - for at least 1 year
  - and completes a practice assessment

Public Reporting of Physician "Quality"

- ## Proposed "Physician Compare"
  - Similar to "Hospital Compare"
- ## Open Questions
  - Individual or group level?
  - Types of measures to be reported?
  - How to permit review (correction) of data by eligible professionals?
  - How to make meaningful to patients?

2. ACCOUNTABLE CARE ORGANIZATIONS

- PPACA § 3022 requires CMS to launch the first ACOs by January 1, 2012

- <u>Who can organize</u>: any configuration of MDs, group practices, hospitals, ASCs

- For Medicare, the ACO must be accountable for the quality, cost and overall care of the Medicare beneficiaries assigned to it (min. 5,000)

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ACO ≈ Gainsharing

- Participating providers collect their usual payments from Medicare but may share among themselves any savings achieved above a threshold amount.

  – Incentive to reduce quantity or extent of services?

  – Stark, Anti-Kickback and Antitrust Issues

  – Agencies working on regs to resolve the conflict

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3. MEDICARE'S VALUE-BASED PURCHASING (VBP) INITIATIVE

"Health care reform legislation portends CMS being able to pay differentially based on the value of care provided."

$$Value = \frac{quality}{cost}$$

A Resource Use Feedback Loop

- ## Affordable Care Act §3003
  - Under the Physician Feedback/Value Modifier Program, CMS uses claims data to create confidential reports measuring physicians' and medical practice groups'
    - resource use
    - quality of care
    - relative comparisons of patterns of resource use/cost among medical professionals and groups

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Resource Use Field Study

- 2009: Completion of <u>Phase I</u> of Physician Resource Use Measurement and Reporting (RUR) Program
  - under §131 MIPPA 2008.

- <u>Phase II</u>
  1) 2010: distribute reports on quality/cost to MD groups in the same 12 metro areas. Obtain feedback to assess electronic tools and processes.
  2) 2011: involve stakeholders in creating composite cost and quality scores.

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Value-Based Payment Modifier

-- Here it comes –

- ACA §3007 requires CMS to apply a value-based payment modifier when calculating payment for a physician claim, starting in 2015.

- By 2017, most physicians will be seeing the modifier in application.

4. INCENTIVE PROGRAMS FOR USE OF EHRs

American Recovery and Reinvestment Act of 2009 (ARRA)

Health Information Technology for Economic and Clinical Health Act (HITECH Act)

"We have lots of information technology, we just don't have any information"
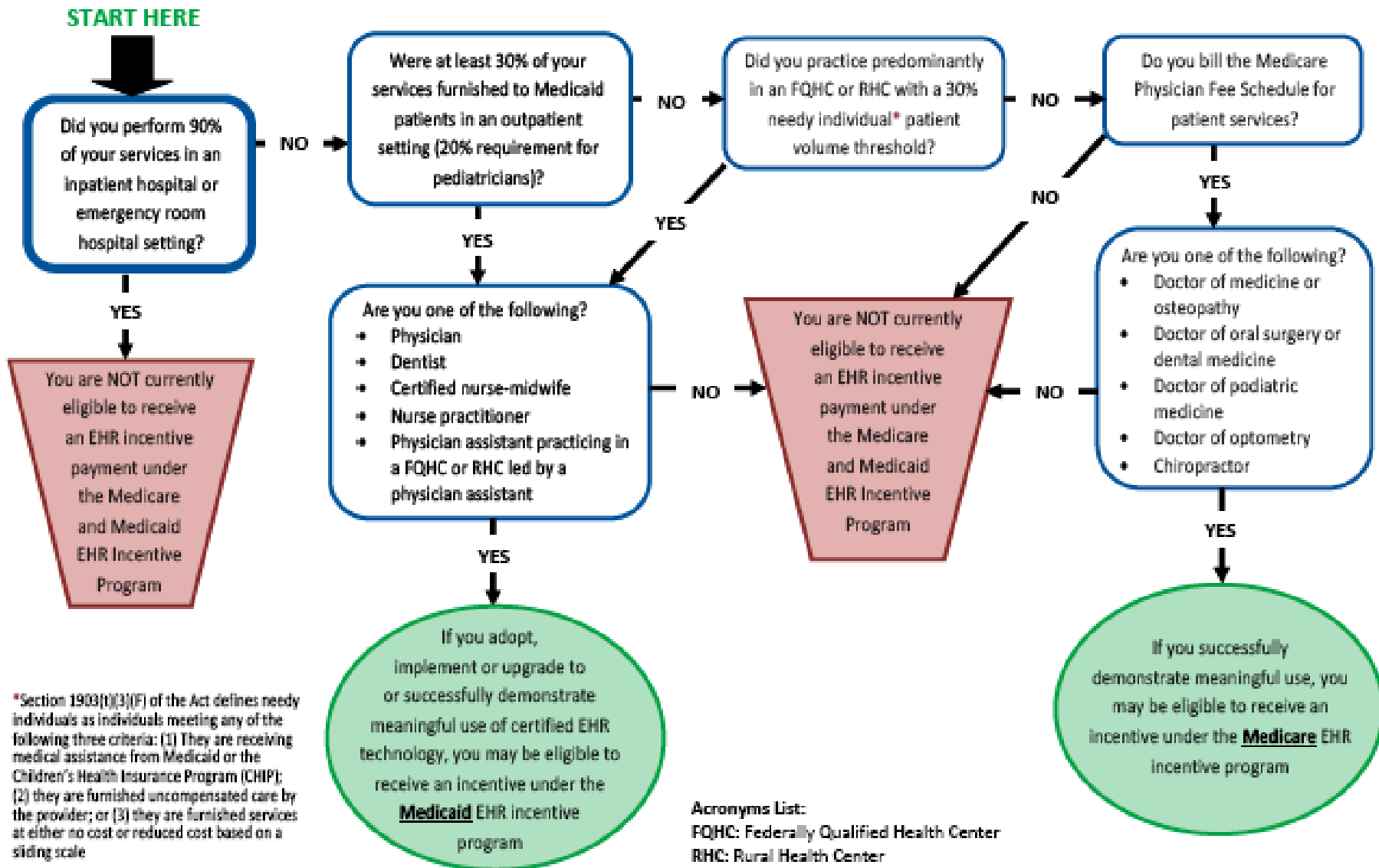
HITECH Act Incentive Amounts for Eligible Professionals

- 2011-2016 (Medicare) –Up to $44,000 over 5 years if "meaningful EHR user"

- 2011-2021 (Medicaid) –Up to $63,750 over 6 years –Adopt/Implement/Upgrade or meaningful use in Year 1, MU Years 2-6

- 2015 and later –If not "meaningful EHR user" up to 3% reduction in Medicare payment

Flow Chart to Help Eligible Professionals (EP) Determine Eligibility for the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs

How to Use this Flow Chart: A Medicaid eligible professional may also be eligible for the Medicare incentive and should follow the path of answering no to the question of Medicaid patient volume to determine Medicare eligibility. An eligible professional who qualifies for both programs may only participate in one program. Eligible Professionals eligible to receive EHR incentive payments under Medicare or Medicaid will maximize their payments by choosing the Medicaid EHR Incentive Program.

START HERE

Did you perform 90% of your services in an inpatient hospital or emergency room hospital setting?

NO →

Were at least 30% of your services furnished to Medicaid patients in an outpatient setting (20% requirement for pediatricians)?

NO →

Did you practice predominantly in an FQHC or RHC with a 30% needy individual* patient volume threshold?

NO →

Do you bill the Medicare Physician Fee Schedule for patient services?

YES ↓ (from 90% question)

You are NOT currently eligible to receive an EHR incentive payment under the Medicare and Medicaid EHR Incentive Program

YES ↓ (30% Medicaid) / **YES** (FQHC/RHC)

Are you one of the following?
- Physician
- Dentist
- Certified nurse-midwife
- Nurse practitioner
- Physician assistant practicing in a FQHC or RHC led by a physician assistant

NO → **NO** →

You are NOT currently eligible to receive an EHR incentive payment under the Medicare and Medicaid EHR Incentive Program

YES ↓

If you adopt, implement or upgrade to or successfully demonstrate meaningful use of certified EHR technology, you may be eligible to receive an incentive under the **Medicaid** EHR incentive program

YES (bill Medicare) ↓

Are you one of the following?
- Doctor of medicine or osteopathy
- Doctor of oral surgery or dental medicine
- Doctor of podiatric medicine
- Doctor of optometry
- Chiropractor

NO →

YES ↓

If you successfully demonstrate meaningful use, you may be eligible to receive an incentive under the **Medicare** EHR incentive program

*Section 1903(t)(3)(F) of the Act defines needy individuals as individuals meeting any of the following three criteria: (1) They are receiving medical assistance from Medicaid or the Children's Health Insurance Program (CHIP); (2) they are furnished uncompensated care by the provider; or (3) they are furnished services at either no cost or reduced cost based on a siding scale

Acronyms List:
FQHC: Federally Qualified Health Center
RHC: Rural Health Center

Did you get all those boxes and lines?

- Go to the CMS page on the EHR Incentive Programs: http://www.cms.gov/EHRIncentivePrograms/downloads/eligibility_flow_chart.pdf

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Hospital-Based Professionals

- Only 57.5% of anesthesia services are in the hospital setting (Medicare data)
- If not hospital-based, payment reductions:
  - 2015   -1%
  - 2016   -2%
  - 2017…   -3%
- So most anesthesiologists will be eligible professionals
  - and must demonstrate "meaningful use" of certified EHR to avoid penalties

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Meaningful Use

1. Use of certified EHR in a meaningful manner (ex: e-prescribing)

2. Use of certified EHR technology for electronic exchange of health information to improve quality of health care

3. Use of certified EHR technology to submit clinical quality and other measures

Meaningful Use Proposed Regulation

First Requirement: 25 "functionalities" of an EHR (Phase 1)

- AIMS (80% reporting threshold):
  - ✓ Record demographics
  - ✓ Record and chart changes in vital signs
  - ✓ Maintain active medication list
  - ✗ Check insurance eligibility electronically
  - ✗ Submit claims electronically
  - ✗ Provide patients with an electronic copy of their health information upon request

Meaningful Use Proposed Regulation Cont'd

2nd Requirement of an EHR

- Submit specific clinical quality measures
  - Core measures (primary care) <u>and</u>
  - Specialty measures – none for anesthesiology.

Damned If You Do, Damned If You Don't?

- ASA working for a CMS solution for anesthesiologists
- Jason Byrd explained, AAA Listserv December 2,
  - "at this time there are very few, if any, certified AIMS systems out there and it is unclear whether all vendors will seek certification as they are waiting for some guidance as well. There are also questions of whether an anesthesiologist would need to use a combination of a hospital's EHR and an AIMS system to meet meaningful use or whether they could simply use an AIMS and be exempt from the other requirements.

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ASA To Fix EHR Incentive cont'd

"ASA has met with both CMS and the Office of National Coordinator (ONC) and educated them on these issues. We are hoping that CMS will come out with some guidance for anesthesiologists as to how they can achieve meaningful use and receive the incentive payments or, at the very least, have hospitals obtain credit for the use of AIMS while allowing anesthesiologists to avoid penalties."

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Compliance
Presented by:
Abby Pendleton, Esq.
The Health Law Partners, P.C.
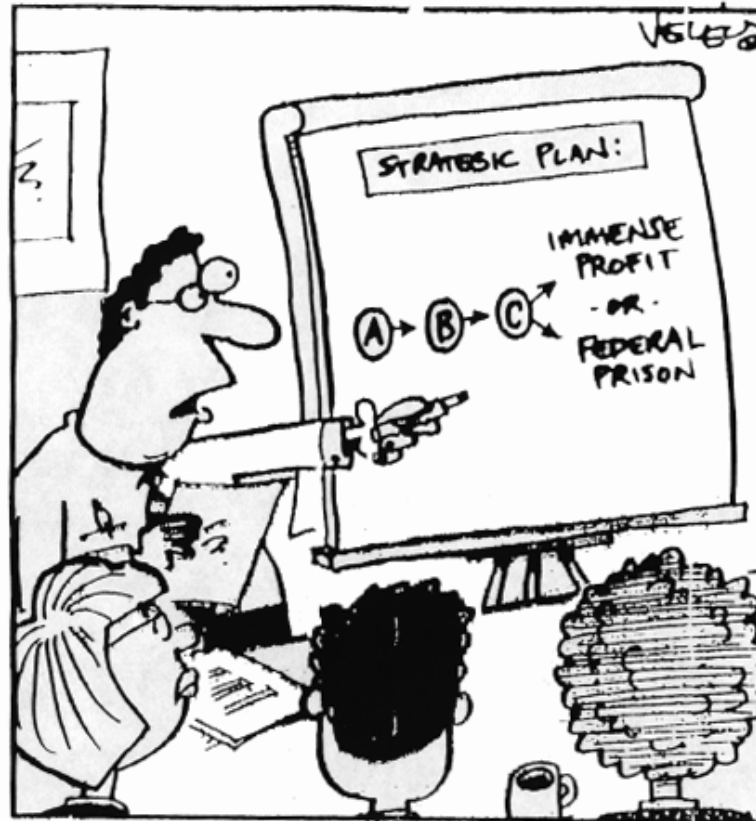
What's New In Compliance

- Mandatory Compliance
- False Claims
- EHR Risks
- The New OIG Roadmap for Physicians – Released November 5, 2010

Compliance

- Increased importance given audit environment – RACs, ZPICS, and more!

- Health Reform Mandates

- Goal of Compliance:
  - Reduce appreciable risks by:
    - Identifying risks or problematic areas
    - Educating
    - Developing policies
    - Monitoring compliance

Compliance Environment
False Claims

- Presentation of "false … or fraudulent claim."
- Treble (3x) damages plus $5,000 to $10,000 forfeiture for each false "claim" presented for a payment.
- False Claims Act permits the United States to intervene and take over "qui tam" lawsuits by private whistleblowers
- No proof of specific intent to defraud is required.
  - 31 USC § 3729(b)
- Knowing or knowingly means that a person with respect to information:
  - **Has actual knowledge**
  - **Acts in reckless disregard of the truth or falsity of the information; or**
  - **Acts in deliberate ignorance of its truth or falsity**

Environment-Compliance and Health Care Reform

- Mandatory compliance programs
    - Section 6401(a)(7) of the Patient Protection and Affordable Care Act ("PPACA" or the "health care reform bill") included provisions mandating compliance programs as part of the Medicare enrollment process.
    - According to the health care reform bill, providers or suppliers within particular industries or categories, as yet unspecified, must have a compliance program in place as a condition of enrollment. Regulations will be issued which will specify the required elements of compliance, timelines and other details regarding implementation.
    - September 23, 2010 Issuance of Proposed Approach and Solicitation of Comments
    - What can physicians expect?

Environment-Return of Overpayments and Health Care Reform

- <u>Mandatory return and reporting of overpayments</u> within 60 days after the date on which the overpayment is identified or the date any corresponding cost report is due along with a written explanation for the overpayment. Retention of an overpayment beyond the 60 day deadline is deemed an "obligation" under the civil False Claims Act (FCA) thereby subjecting the provider or supplier to treble damage and civil penalty liability.

- PPACA- Section 6402(a).

OIG-A Roadmap for New Physicians

- November 5, 2010 release

- Tool for training

- Addresses

  – Relationships with payers

  – Relationships with other physicians and providers

  – Relationships with vendors

Documentation is Critical

- Documentation issues predominate in audits and other cases

- OIG notes: "one of the most important physician practice compliance issues"- OIG states:

- The record should be complete and legible;

- Each encounter should include the reason, relevant history, exam findings, prior test results, assessment, clinical impression or diagnosis, plan of care, date and identity of observer

- Electronic Record Documentation Issues/Issues in Audits

  - Template issues

  - Populating issues

  - Signatures

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Compliance

- A PHYSICIAN IS LEGALLY RESPONSIBLE FOR THE ACCURACY OF CLAIMS SUBMITTED UNDER HIS OR HER BILLING NUMBER

  – Medical necessity

  – Documentation issues

Compliance: Medical Necessity is Key

- All services billed **must be** reasonable and necessary
- Who determines medical necessity?
- LCD and NCP provisions
- Medical Necessity Documentation- Pain
  - Pain history
    - prior treatments and responses
  - Reason for encounter → each encounter
  - Diagnosis/indication for procedure
  - Use of Patient diaries/self-report scales
  - Documentation of location/intensity of pain, etc.
- Medical necessity and anesthesia

Documentation

- Anesthesia time issues
  - Rounding
  - Documentation to support start and stop times
  - Others
- Medical direction documentation:
  - The physician alone inclusively documents in the patient's medical record that the conditions set forth in paragraph (a)(1) have been satisfied, specifically documenting that he or she performed the pre-anesthetic exam and evaluation, provided the indicated post-anesthesia care, and was present during the most demanding procedures, including induction and emergence where applicable.

Documentation

- Per 42 CFR §415.110, medical direction requires that for each patient the anesthesiologist fulfill the following seven (7) specific responsibilities:
  - Performs the pre–anesthetic exam and evaluation
  - Prescribes the anesthesia plan
  - Participates in the most demanding procedures of the anesthesia plan including, if applicable, induction and emergence
  - Ensures that any procedures in the plan that he/she does not perform are performed by a qualifying individual
  - Monitors the course of anesthesia at frequent intervals
  - Remains physically present and available for immediate diagnosis and treatment of emergencies
  - Provides indicated post-anesthesia care

Documentation

- Must focus on enhancement of medical direction documentation:
  - Discussion of various methods
    - Individual attestations
    - Global attestations
    - Handwritten entries
    - Time line initialing

THANK YOU

- ## Questions to info@anesthesiallc.com

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