



# WHAT'S NEW IN ANESTHESIA

# Deleted Anesthesia Codes

- **01935/5 units**
- Percutaneous spinal procedures, diagnostic
- **01936/5 units**
- Percutaneous spinal procedures, therapeutic

# New Anesthesia Codes Shorthand Version

01937/4 units – Facets/TFE C/T spine

01938/4 units – Facets/TFE L/S spine

01939/4 units – RFA C/T spine

01940/4 units - RFA L/S spine

01941/5 units – Kypho/vertebro C/T spine

01942/5 units - Kypho/vertebro L/S spine



# Anesthesia for Facets & ESIs

New ESI LCDs state anesthesia not allowed:

Except for “exceptional and unique cases”

New Facet LCDs disallow anesthesia:

Except for “rare, unique circumstances”

Have to document the unique circumstances

# RVG Parentheticals

- 00352 – major vessels of neck, simple ligation
  - “For radiological procedure” see 01916-01933, 01937-01942,
  - 00846 – radical hysterectomy
  - “Includes uterus transplant”
  - 01922 – noninvasive imaging or radiation therapy
  - “for percutaneous image-guided procedures on spine or spinal cord, see codes 01937—1942”
- 01991 & 01992 -  
Dx/therapeutic nerve blocks
  - “for percutaneous image-guided procedures on spine or spinal cord, see codes 01937—1942”

## New TEE Add-on Code

- **93319**

“3D echocardiographic imaging and postprocessing during transesophageal echocardiography, or during transthoracic echocardiography for congenital cardiac anomalies, for the assessment of cardiac structure(s) ...(List separately in addition to code for echocardiographic imaging).”

- This is an add-on code; bill in addition to:

93303 – TTE for congenital cardiac anomalies

93304 – Same, but limited study

93312 – TEE placement and interpretation

93314 – TEE interpretation only

93315 - TEE for congenital cardiac anomalies

93317 – Same, but interpretation only

# Crosswalk Changes

- **30 spinal procedures have new ASA cross due to deletion of 01935 and 01936**

19 codes - same base units (5 units)

12 codes – lower based units (4 units vs. 5 units)

9 codes - use 00300/5 units when imaging is not performed

# Crosswalk Changes

## **58957**

Old cross 00840/6 units or 00790/7 units

New Cross 00846/8 units (no alternates)

## **40490**

Old Cross 00300/5 units

No Cross for 2022 – Anesthesia Not Typically Required

## **58674**

Old Cross 000860/6 units

New Cross 00840/6 units

Same unit value

# CMS Changed Base Units

- 00537 (EP procedures)

RVG has 10 units

CMS previously paid 7 units

CMS will now pay 10 units

2022 Fee Schedule; pp 212-215

# What's Not Changed

- No other changes to TEE codes
- 36556 (CVL)
- 36620 (Art line)
- Blocks (64400 – 64450)
- Epidurals (62320-62327)
- PVB & TAP Blocks (64461-64489)

# Coding to the Highest Degree of Specificity

- There is a vast amount of unspecified diagnosis code reporting when more specific diagnoses are documented in the health record. Coding professionals must continually train their “coder eye” to look for specificity in provider documentation. A finely tuned “coder eye” and attention to the level of specificity available in the ICD-10-CM code set will ensure the highest degree of specificity of the codes assigned and reported.
- Diagnosis codes ending in the numbers zero or nine are often indications that an unspecified diagnosis code was assigned. A quick second review of the clinical documentation associated with these codes may reveal clinical details needed to derive a more specific diagnosis code

## Coding Example A

- For this example, the documentation in the outpatient setting is as follows: the emergency department provider documents a “non-displaced right talus fracture.” The right ankle X-ray documents a “non-displaced avulsion fracture of the right talus.”
- The code S92.101A, Unspecified fracture of right talus, was initially assigned. After a final review, the code S92.154A, Nondisplaced avulsion fracture of right talus, is assigned based on the greater specificity found in the imaging report.

## Coding Example B

- For this example, the documentation in the inpatient setting is as follows: the history and physical and discharge summary document that the patient suffered an “embolic cerebral infarction with residuals.” The brain CAT scan report documents a “large embolus in the right middle cerebral artery (MCA) territory.”
- The code I63.40, Embolic cerebral infarction of unspecified artery, was initially assigned. After a final review, I63.411, Cerebral infarction due to embolism of right middle cerebral artery, should be assigned based on greater specificity found in the brain CT report.

# Addressing Nonspecific Documentation and Coding

- Despite the importance of specific documentation and diagnosis code reporting, nonspecific documentation and coding persists. The solution lies in addressing both improvements in the specificity of clinical documentation and process improvement to ensure medical coding professionals are coding to the highest degree of specificity that is available. The goal is to report specific diagnosis codes when they are supported by the available medical record documentation and clinical knowledge of the patient's health condition—and use unspecified codes **only** when they are the best choice to accurately reflect the healthcare encounter.