Executive Director's Page

Congress Comes to the Rescue (or Preparing for the 2004 Elections)

By Barbara Baldwin, CSA Executive Director

Once again Congress has done what the Centers for Medicare and Medicaid Services can't. In a burst of energy a congressional conference committee reached an agreement on a prescription drug benefit for Medicare beneficiaries. Included in the agreement is a 1.5% increases in physician payments for 2004 and 2005. It supercedes the Medicare fee schedule update published in the November 7 Federal Register, which promised a 4.5% reduction in physician payments in 2004. With campaigning for next year's elections already begun and stern cautionary comments from the American Association of Retired Persons, the chances of the bill passing were very favorable.

The agreement also provides bonus payments to physicians in scarcity areas in 2005, 2006 and 2007. Additionally, it brings the floor of the work geographic payment adjuster in the payment formula to 1.0 in 2004 through 2006, which means all doctors would be paid 100% of the national average. Here is how the anesthesia conversion factors compare under the proposed CMS cuts of 4.5% reduction vs. the 1.5% increase.

Table 1. Proposed and Final 2004 Anesthesia Conversion Factors

GPCI Area #	Geographic Area	2003 CF	CMS -4.5%	Congress +1.5%*
26	Anaheim/Santa Ana, CA	17.92	17.25	18.19
18	Los Angeles, CA	18.08	17.39	18.35
3	Marin/Napa/Solano, CA	17.45	16.71	17.71
7	Oakland/Berkeley, CA	17.77	17.01	18.04
5	San Francisco, CA	18.65	17.85	18.93
6	San Mateo, CA	18.32	17.53	18.59
9	Santa Clara, CA	18.35	17.55	18.62
17	Ventura, CA	17.45	16.73	17.71
99	Rest of California	16.92	16.23	17.17

*Amounts may vary slightly in final computations. See the CSA Web Site at **www.csahq.org** for final conversion factors.

The 2004 CPT also includes revised instructions for code 01996 (daily hospital management of epidural or subarachnoid continuous drug administration). The 2003 CPT uses different codes for daily epidural management, based on the reason the catheter was originally inserted. For epidural catheters placed for postoperative pain management only, epidural codes 62318 or 62319 are reported for placement of the catheter along with the anesthesia code for the surgical procedure. Daily management of the epidural catheter is billed using an E & M code, such as 99231 or 99232. If the epidural cathethr is used for both anesthesia and post-op pain control, only the anesthesia code for the surgical procedure is billed. The epidural code 62318 or 62319 is not billed. Follow-up care of the epidural catheter is billed using 01996. Needless to say, this distinction has caused great confusion because the same service, daily management of the epidural catheter, has different codes.

Beginning January 1, 2004, anesthesiologists no longer are to use E&M codes instead of 01996 if the epidural was placed solely for postoperative pain management. The instructions for the corresponding epidural codes, 62318 and 62319, have also been revised to reflect that 01996 is the correct code for daily management of the epidural in all instances. Following are the code changes and additions in the 2004 RVG.

Table 2. Anesthesia Code Changes for 2004

	Code	Descriptor	ASA Base Unit Value
Revised	00528	Anesthesia for closed chest procedures; mediastinoscopy and diagnostic thoracoscopy **not utilizing one lung ventilation**	8 + time
New	00529	Anesthesia for closed chest procedures; mediastinoscopy and diagnostic thoracoscopy utilizing one lung ventilation	11 + time
New	01173	Anesthesia for open repair of fracture disruption of pelvis or column fracture involving acetabulum	12 + time
Deleted	~~01175*~~	~~Anesthesia for open repair of pelvic acetabular fractures.~~ (Deleted from RVG. Never part of CPT)	
New	01958	Anesthesia for external cephalic version procedure	5 + time

Revised	01996	Daily **hospital** management of epidural or subarachnoid **continuous** drug administration. (RVG revision to conform to CPT)	3
Deleted	~~01997**~~	~~Daily hospital management of intravenous patient-controlled analgesia.~~ (Deleted from RVG. Never part of CPT)	

The ASA proposed three new pain codes that were adopted by the CPT Editorial Panel and the RUC (which recommends relative values to CMS for adoption). The American Society for Interventional Pain Physicians and the American Academy of Pain Medicine were instrumental in this effort. Table 3 shows the new codes as well as changes to existing pain codes.

Table 3: Pain Coding Changes for 2004

	Code	Descriptor	ASA Base Unit Value*
Revised	20550	Injection(s); **single** tendon sheath, **or** ligament**, aponeurosis (e.g., "plantar fascia")**	3
Revised	20551	Injection(s); **single** tendon origin/insertion	3
Revised	20552	**Injection(s)**; single or multiple trigger point(s), one or two muscles	3
New	64449	Injection, anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement) including daily management for anesthetic agent administration	12
New	64517	Injection, anesthetic agent; superior hypogastric plexus	10
Revised	64680	Destruction by neurolytic agent, ~~celiac plexus,~~ with or without radiologic monitoring**; celiac plexus**	20
New	64681	Destruction by neurolytic agent, with or without radiologic monitoring; superior hypogastric plexus	16

Revised	95990	Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular);	I.C.
New	95991	Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular); administered by physician	3

*Many payers use the RBRVS relative values instead of ASA suggested values

Four central venous access placement procedures, 36488-36491, have been deleted from the CPT and four new codes added:

Table 4: Central Venous Access Procedures for 2004

	Code	Descriptor	ASA Base Unit Value*
New	36555	Insertion of non-tunneled centrally inserted central venous catheter; under 5 years of age	5
New	36556	Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older	4
New	+75998	Fluoroscopic guidance for central venous access device placement, replacement (cathether only or complete), or removal (includes fluoroscopic guidance for vascular access and catheter manipulation, any necessary contrast injections through access site or catheter with related venography, radiologic supervision and interpretation, and radiographic documentation of final catheter position) (List separately in addition to code for primary procedure)	2
New	+76937	Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent realtime ultrasound visualization of vascular needle entry, with permanent recording and reporting (List separately in addition to code for primary procedure)	1

*many payers use the RBRVS relative values instead of ASA suggested values
+add-on code