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• Have a direct impact upon continuously improving their coding processes.

• Assure that documentation precisely/correctly supports physicians’ coding decisions.

• Provides valuable updates that physicians incorporate into their day-to-day coding, documentation and billing functions to maintain audit risk reduction.

Today, and certainly going forward, a key manner of enhancing practice profitability is to support efforts that assure reimbursement while avoiding the risks of third party audits. Such audits can result in significant pull-backs of revenue together with potential fines and related problems. When correct coding and effective billing processes are combined with accurate documentation, practice outcomes are improved while the risks and costs of highly technical third party audits are reduced.

We embrace the value that physicians provide for the population, together with a clear knowledge of the inevitability of change in how healthcare services are reimbursed. We look forward to providing physicians with the knowledge and know-how that is necessary to effectively and correctly address the changes that will become more prevalent. By applying our expertise, technology and in-depth understanding of these intricacies we can better assist physicians to receive full value for their services.
**Coding Corner**

Sharon Donelli, CPC, CPC-H
Administrative Officer

**Paravertebral Facet Codes**

**Are New For 2010**

Be sure your charge tickets are updated with the following codes for 2010:

- 64490 – Paravertebral facet block, cervical or thoracic, single level
- 64491 - ..........second level
- 64492 - ..........third and any addtl level
- 64493 – Paravertebral facet block, lumbar or sacral, single level
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- 64495 - ..........third and any addtl level

Note: Image guidance (fluoroscopy or CT) and any injection of contrast are inclusive components of 64490-64495 and should not be billed separately. In simpler terms: (1) When the physician uses imaging needle guidance, determine whether it is CT or fluoroscopy and refer to codes 64490-6449; (2) If the physician uses imaging needle guidance and it is an ultrasound, refer to codes 0213T-0218T; (3) When the physician does not use imaging needle guidance, refer to codes 20550-20553.

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**What's the Temperature?**

It matters more than ever in 2010! Beginning on January 1st of this year, anesthesia providers were given a new measure to report under the Physician Quality Reporting Initiative—Perioperative Temperature Management or Measure #193.

Providing some background on PQRI, in 2006 the Tax Relief and Health Care Act (TRHCA) required the establishment of a physician quality reporting system, including an incentive payment for eligible professionals (EPs) who satisfactorily report data on quality measures for covered professional services furnished to Medicare beneficiaries during the second half of 2007 (the 2007 reporting period). CMS named this program the Physician Quality Reporting Initiative (PQRI).

The PQRI was further modified as a result of the Medicare, Medicaid and SCHIP Extension Act of 2007 (MMSEA) and the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).

For each program year, CMS implements PQRI through an annual rule-making process published in the Federal Register. New measures are introduced, and in some cases, old ones are deleted.

At the beginning of the program, anesthesiologists had only one measure available to them—Measure #30: “Perioperative Care: Timely Administration of Prophylactic Parenteral Antibiotics”. Later, measure #76 was added—Prevention of Catheter-Related Bloodstream Infections: Central Venous Catheter (CVC) Insertion Protocol.

Most recently, Measure #193—Perioperative Temperature Management—has been introduced. CMS defines this measure as:

> “Percentage of patients, regardless of age, undergoing surgical or therapeutic procedures under general or neuraxial anesthesia of 60 minutes duration or longer, except patients undergoing cardiopulmonary bypass, for whom either active warming was used intraoperatively for the purpose of maintaining normothermia, OR at least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) was recorded within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time.”

The measure is looking to ensure that anesthetists record the patient’s body temperature within a 45 minute time span that must occur in between the last 30 minutes of the anesthesia end time and the first 15 minutes following the end time OR indicate when active intraop warming was used. “Active warming” is limited to over-the-body active warming (e.g., forced air, warm-water garments, and resistive heating blankets).

If any of the above measures could not be performed for medical reasons, it’s important to document the reason. This will allow IPMS coders to append the appropriate modifier to Medicare. Doing so ensures that your group will receive credit for considering the measure for an otherwise-eligible case and still count towards the 80% threshold needed to receive the PQRI financial bonus.

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**A Message From IPMS**

(continued from page 1)

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—Tina Scavetta
Account Manager

Workplace Wellness Programs Work

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U.S. researchers followed 757 hospital workers who took part in a voluntary 12-week team-based wellness program that focused on diet and exercise. The participants’ weight, lifestyle behavior and heart disease risk factors were collected at the start, end and one year after the program ended.

At the start of the study, 33% of participants were overweight (BMI of 25 to 29.9) and 30% were obese (BMI of 30 or more). The study found that obese participants lost the most weight—3% at 12 weeks and 0.9% at one year—and were most likely to reduce their intake of dietary sugar. Overweight participants had an average weight loss of 2.7% at 12 weeks and 0.4% at one year. The study shows that all participants had similar improvements in levels of physical activity, along with lower cholesterol and blood pressure levels, and reduced waist circumferences at the end of the program and a year after the program ended.

"Voluntary wellness programs can successfully address weight loss and lifestyle behaviors for employees in all weight categories, but more work is needed to improve long-term changes," the Massachusetts General Hospital researchers concluded.

The study was presented at the American Heart Association’s Nutrition, Physical Activity and Metabolism Conference in San Francisco in March, 2010.

Additional research presented at the conference included a study that found aerobic exercise reduces levels of inflammatory markers in men with heart disease. The Polish study included 100 men, average age 55, who’d had coronary artery bypass surgery about two months previously to treat angina pectoris—chest pain experienced during physical activity. They were randomly selected to be in a control group or a group that did six weeks of exercise training, three times a week, at 60% to 80% of maximum heart rate.

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