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CHAPTER II
ANESTHESIA SERVICES
CPT CODES 00000-09999
FOR
NATIONAL CORRECT CODING POLICY MANUAL
FOR PART B MEDICARE CARRIERS

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Chapter II
Anesthesia Services
CPT Codes 00000 - 09999

A. Introduction

Anesthesia care conventionally includes all services associated with the administration of analgesia/anesthesia, provided by an anesthesiologist and/or certified registered nurse anesthetist (CRNA)[1] to a patient undergoing a surgical or other invasive procedure so that intervention can be undertaken. This may involve local, regional, epidural, general anesthesia or monitored anesthesia care (MAC), and usually involves administration of anxiolytics or amnesia-inducing medications. Additionally, anesthesia care includes evaluating preoperatively the patient with a sufficient history and physical examination so that the risk of adverse reactions can be minimized, planning alternative approaches to accomplishing anesthesia and answering all questions regarding the anesthesia procedure asked by the patient.

The anesthesiologist assumes responsibility for the post-anesthesia recovery period which is included in the anesthesia care package. It encompasses all care until the patient is released to the surgeon or another physician; this point of release generally occurs at the time of release from the post-anesthesia recovery area.

B. Standard Anesthesia Coding

The following policies reflect national Medicare correct coding guidelines for anesthesia services.

1. Principles of Medicare coding for anesthesia services involving administration of anesthesia are reported by the use of

[1]In the following, the term ACRNA@ is to be interpreted as including anesthesiologists= assistants the anesthesia five digit CPT procedure codes (00100-01860). Subsequent CPT codes (01904-01922) are unique to anesthesia for interventional radiology. These codes specify "Anesthesia for." followed by a general area of surgical intervention. Several CPT codes (01990-01999) describe miscellaneous anesthesia services.

Anesthesia services are provided by or under the supervision of a physician. These services may include, but are not limited to, general or regional anesthesia and monitoring of physiological parameters during local or peripheral block anesthesia with sedation (when medically necessary), or other supportive services in order to afford the patient anesthesia care deemed optimal by the anesthesiologist during any procedure.

Anesthesia codes describe a general anatomic area or service which usually relate to a number of surgical procedures, often from multiple sections of the CPT manual. For Medicare purposes, only one anesthesia code is reported. It is acceptable to bill the code that accurately describes the anesthesia for the procedure which has the highest basic unit value.

2. Another unique characteristic of anesthesia coding is the reporting of time units for time spent delivering anesthesia. In contrast to some evaluation and management services which can be coded based on time, payment for anesthesia services varies with or increases with increments of time. In addition to billing a basic unit value for an anesthesia service, the units of service reflecting the time of anesthesia attendance are reported. Anesthesia time involves the continuous actual presence of the anesthesiologist and starts when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room or equivalent area and ends when the anesthesiologist is no longer in personal attendance, i.e., when the patient may be safely placed under postoperative supervision. Non-monitored interval time may not be considered for calculation of time units.

Example: A patient who undergoes a cataract extraction may require monitored anesthesia care (see below). This may require administration of a sedative in conjunction with a peri/retrobulbar injection for regional block anesthesia. Subsequently, an interval of 30 minutes or more may transpire during which time the patient does not require monitoring by an anesthesiologist/certified registered nurse anesthetist. After this period, monitoring will commence again for the cataract extraction and ultimately the patient will be released to the surgeon=s care or to recovery. The time that may be reported would include the time for the monitoring during the block and during the procedure. The Ainterval@ time and the recovery time are not to be included in the time unit calculation. Also, if unusual services, not bundled into the anesthesia service, are

required, the time spent delivering these services before anesthesia time begins or after it ends may not be included as reportable anesthesia time, either.

However, if it is medically necessary for the anesthesiologist/CRNA to be in direct one to one observation, monitoring the patient during the interval time, and not billing any other service, the time can be included.

3. It is standard medical practice for an anesthesiologist/ CRNA to provide a patient examination and evaluation prior to surgery. This is considered part of the anesthesia service. The time spent in performing the evaluation is included in the base unit of the code and therefore, is not included as anesthesia time. If surgery is canceled, either because of other circumstances or because of findings on the preoperative evaluation the anesthesiologist and cancellation occurs subsequent to the preoperative evaluation, payment may be allowed to the anesthesiologist for an evaluation and management service and the appropriate E & M code (usually a consultation code) may be reported.

Similarly, routine postoperative evaluation is included in the basic unit for the anesthesia service. Additional time units would be inappropriate and evaluation and management codes are not to be used in addition to the anesthesia code. Postoperative evaluation and management services related to the surgery are not separately payable to the anesthesiologist except in the circumstance where the anesthesiologist is providing significant, separately identifiable services such as ongoing critical care services, postoperative pain management services, or extensive unrelated ventilator management. Management of epidural or subarachnoid drug administration (CPT code 01996) is separately payable on dates of service subsequent to surgery but not on the date of surgery. If the only service provided is management of epidural/subarachnoid drug administration, then an evaluation and management service is not appropriate in addition to CPT code 01996. Payment for management of epidural/subarachnoid drug administration is limited to one unit of service per postoperative day irrespective of the number of visits necessary to manage the catheter per postoperative day (CPT definition). While an anesthesiologist or CRNA may be able to bill for this service, only one payment will be made per day. Postoperative pain management services are generally provided by the surgeon

who is reimbursed under a global payment policy related to the procedure and shall not be reported by the anesthesiologist unless separate, medically necessary services are required that cannot be rendered by the surgeon. The surgeon is responsible to document in the medical record the reason care is being referred to the anesthesiologist.

In certain circumstances critical care services are provided by the anesthesiologist. It is currently national HCFA policy that CRNAs cannot be reimbursed for evaluation and management services in the critical care area. In the case of anesthesiologists, the routine immediate postoperative care is not separately reported except as described above. Procedural services such as placement of lines, emergency intubation (outside of the operating suite), etc. are payable to anesthesiologists as well as CRNAs if these procedures are furnished within the parameters of appropriate state licensing laws.

4. One principle of CPT coding is that if a service is usually provided as part of a more comprehensive service, then it should be included in and be considered part of the service. The advances in technology allow for intraoperative monitoring of a variety of physiological parameters. The following preparation/monitoring services are integral to anesthesia services in general and are not to be separately reported:

- A Transporting, positioning, prepping, draping of the patient for satisfactory anesthesia induction/surgical procedures.
- A Placement of external devices necessary for cardiac monitoring, oximetry, capnography, temperature, EEG, CNS evoked responses (e.g. BSER), doppler flow.
- A Placement of peripheral intravenous lines necessary for fluid and medication administration.
- A Placement of airway (endotracheal tube, orotracheal tube, etc.)
- A Laryngoscopy (direct or endoscopically) for placement of airway (endotracheal tube, etc.)
- A Placement of naso-gastric or oro-gastric tube.

- A Intraoperative interpretation of monitored functions (blood pressure, heart rate, respirations, oximetry, capnography, temperature, EEG, BSER, Doppler flow, CNS pressure).
- A Interpretation of laboratory determinations (arterial blood gases such as pH, pO_2, pCO_2, bicarbonate, hematology, blood chemistries, lactate, etc.) by the anesthesiologist/CRNA.
- A Nerve stimulation for determination of level of paralysis or localization of nerve(s). Codes for EMG services are for diagnostic purposes for nerve dysfunction; to report these codes a complete report must be present in the medical record.

When the following CPT codes are reported with an anesthesia code, it is assumed that these services are being reported as part of the anesthesia service and so will not be paid in addition to the anesthesia code. Because it is recognized that many of these procedures may occur on the same date of surgery but are not performed in the course of and as part of the anesthesia provision for the day, these codes will be separately paid only if the -59 modifier is appended to the code, indicating that the service rendered was independent of the anesthesia service.

CPT codes describing services that, when performed as part of the anesthesia service, would be considered included in the anesthesia code include the following partial list:

- A 31505, 31515, 31527 (Laryngoscopy) (Laryngoscopy codes are for diagnostic or surgical services)
- A 31622, 31645, 31646 (Bronchoscopy)
- A 36000 - 36015 (Introduction of needle)
- A 36400-36440 (Venipuncture)
- A Blood sample procurement through existing lines or requiring only venipuncture or arterial puncture
- A 62311, 62319 (Injection of diagnostic or therapeutic substance)CPT codes 62310-62311 and 62318-62319 may be reported on the date of surgery if performed for

postoperative pain relief rather than as the means for providing the regional block for the surgical procedure. If a narcotic or other analgesic is injected through the same catheter as the anesthetic, CPT codes 62311 and 62319 should not be billed. The -59 modifier will indicate that the injection was performed for postoperative pain relief but a procedure note should be included in the medical record.

Example: A patient has an epidural block with sedation and monitoring for arthroscopic knee surgery. The anesthesiologist bills for CPT code 01382 for "Anesthesia for arthroscopic procedures of knee joint". The epidural catheter is left in place for postoperative pain management. The anesthesiologist may not also bill for CPT codes 62311(injection of diagnostic or therapeutic substance) or 01996 (daily management of epidural) on the date of surgery. The CPT code 01996 may be reported with one unit of service per day on subsequent days until the catheter is removed. On the other hand, if the anesthesiologist performed general anesthesia and bills for CPT code 01382, and reasonably believes that postoperative pain is likely to be sufficient to warrant an epidural catheter, the CPT code 62319-59 may be reported indicating that this is a separate service from the anesthesia service. In this instance, the service is separately payable whether the catheter is placed before, during, or after the surgery. If the epidural catheter was placed on a different date from the surgery, then the -59 modifier would not be necessary. The CPT code 01996 may only be reported on dates subsequent to the date of billing the CPT code 62311-59.

A 64400-64565 (Nerve blocks)

A 67500 (Retrobulbar injection)

A 81000-81015, 82013, 82205, 82270, 82273
(Performance and interpretation of laboratory tests)

A 90780-90788 (IV infusion - injections)

A 91000, 91055, 91105 (Esophageal, gastric intubation)

A 92511-92520, 92543 (Special otorhinolaryngologic services)

A 92950 (Cardiopulmonary resuscitation)

A 92953 (Temporary transcutaneous pacemaker)

A 92960 (Cardioversion)

A 93000-93010 (Electrocardiography)

A 93015-93018 (Cardiovascular stress tests)

A 93040-93042 (Electrocardiography)

A 93307-93314 (Echocardiography when displayed for monitoring purposes.) When performed for diagnostic purposes with documentation of a formal report, this will be considered a significant, separately identifiable, and separately payable service.

A 93922-93981 (Extremity arterial venous studies) When performed diagnostically with a formal report, this will be considered a significant, separately identifiable, and if medically necessary, a payable service.

A 94640, 94650, 94651 (Inhalation/IPPB treatments)

A 94656, 94660-94662 (Ventilation management/pulmonary services) If performed as management for maintenance ventilation during a surgical procedure, this is part of the anesthesia service. This is separately payable if performed as an ongoing service after transfer out of the operating room or post-anesthesia recovery to a hospital unit/ICU. The -59 modifier would be necessary to signify that this was a separate service.

A 94664-94665 (Inhalations)

A 94680-94690 (Expired gas analysis)

A 94760-94770 (Oximetry)

A 99201-99499 (Evaluation and management)

(This is not a comprehensive list but includes those CPT codes

being addressed at present.)

When a physician performs a procedure and, incidentally, provides the anesthesia, the anesthesia for the procedure is not reported. (The anesthesia for a procedure, if provided by the surgeon, is included in the global surgery package).

When a physician performs a procedure routinely in preparation for administering anesthesia during a procedure performed by a surgeon, these routine procedures are not separately reported.

Anesthesia Code being reported by Anesthesiologist	Service not to be reported separately by Anesthesiologist
CPT code 00530 (Anesthesia for transvenous pacemaker)	71090 (Diagnostic radiology) 76000 (Fluoroscopy)
CPT code 00534 (Anesthesia for transvenous defibrillator)	71090 (Diagnostic radiology) 76000 (Fluoroscopy)
CPT codes 00560-00580 (Anesthesia for Intrathoracic procedures)	71090 (Diagnostic radiology) 76000 (Fluoroscopy) 93501 (Right heart catheterization)
CPT codes 00562 (Anesthesia for heart procedures)	36430 (Blood transfusion) 36600 (Arterial puncture)
CPT codes 01920-01921 (Anesthesia for radiological procedures with cardiac catheterization and angioplasty)	71090 (Diagnostic radiology) 76000 (Fluoroscopy)

(This listing does not include all codes applicable but contains only those CPT codes being addressed at present.)

C. Radiologic Anesthesia Coding

In keeping with standard anesthesia billing guidelines for Medicare, only one anesthesia code may be reported for anesthesia services provided in conjunction with radiological procedures. Radiological Supervision and Interpretation (S&I) codes will usually be applicable to radiological procedures being performed.

The appropriate S&I code may be reported by the appropriate provider (radiologist, cardiologist, neurosurgeon, radiation oncologist, etc.). Accordingly, S&I codes are not included in anesthesia codes referable to these procedures; only the appropriate provider, however, may bill for S&I services.

CPT code 01920 (Anesthesia for cardiac catheterization including coronary arteriography and ventriculography, not to include Swan-Ganz catheter) can be reported for monitored anesthesia care (MAC) in patients who are critically ill or critically unstable. If the physician performing the radiologic service places a catheter as part of that service, and, through the same site, a catheter is left and used for monitoring purposes, it is inappropriate for either the anesthesiologist/certified registered nurse anesthetist or the physician performing the radiologic procedure to bill for placement of the monitoring catheter (e.g. CPT codes 36488-36500).

D. Monitored Anesthesia Care(MAC)(-QS Modifier)

There has been a shift to providing more surgical and diagnostic services in an ambulatory, outpatient or office setting. Accompanying this, there has also been a change in the provision of anesthesia services from traditional general anesthetic to a combination of local or regional anesthetic with certain conscious altering drugs. This type of anesthesia is referred to as monitored anesthesia care if provided directly by a physician or anesthesiologist or by a medically-directed CRNA. In essence, MAC involves patient monitoring sufficient to anticipate the potential need to administer general anesthesia during a surgical or other procedure. MAC requires careful and continuous evaluation of various vital physiologic functions and the recognition and treatment of any adverse changes. HCFA recognizes this type of anesthesia service as a payable service

if medically necessary and reasonable.

Because monitored anesthesia care (MAC) requires at least the same level of monitoring as that of general anesthesia, it is treated the same as general anesthesia except that the -QS modifier must be used for payment purposes. The guidelines as promulgated previously apply equally to MAC. It is particularly important to note that Medicare policy allows only one anesthesia CPT code to be reported, and the time units reported represent only time where the patient was continuously monitored by a physician or anesthesiologist (personally, or medically directing a CRNA.) Preoperative and postoperative assessment follow standard anesthesia billing guidelines.

Issues of medical necessity are addressed by National and Local Contractor Medical Review Policy.

E. Anesthesiologists and CRNAs

HCFA recognizes the services of anesthesiologists as providers and physicians in a supervisory capacity. Anesthesiologists personally performing anesthesia services bill in a standard fashion, in accordance with HCFA regulations as outlined in the Medicare Carriers' Manual (e.g. Sections '4137, '4830, '15018). HCFA also recognizes CRNAs and anesthesiologists= assistants practicing under the medical direction of anesthesiologists or practicing independently of anesthesiologists. Billing instructions and regulations regarding this arrangement are outlined in the Carriers' Manual as noted above and in Section '16003.