CHAP 2.doc
Version 15.3

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

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Chapter II
Anesthesia Services
CPT Codes 00000 - 09999

A. Introduction

The principles of correct coding discussed in Chapter I apply to the CPT codes in the range 00000-01999. Several general guidelines are repeated in this Chapter. However, those general guidelines from Chapter I not discussed in this chapter are nonetheless applicable.

Physicians should report the HCPCS/CPT code that describes the procedure performed to the greatest specificity possible. A HCPCS/CPT code should be reported only if all services described by the code are performed. A physician should not report multiple HCPCS/CPT codes if a single HCPCS/CPT code exists that describes the services. This type of unbundling is incorrect coding.

HCPCS/CPT codes include all services usually performed as part of the procedure as a standard of medical/surgical practice. A physician should not separately report these services simply because HCPCS/CPT codes exist for them.

Specific issues unique to this section of CPT are clarified in this chapter.

Anesthesia care is provided by an anesthesia practitioner who may be a physician, a certified registered nurse anesthetist (CRNA) with or without medical direction, or an anesthesia assistant (AA) with medical direction. The anesthesia care package consists of preoperative evaluation, standard preparation and monitoring services, administration of anesthesia, and post-anesthesia recovery care.

Preoperative evaluation includes a sufficient history and physical examination so that the risk of adverse reactions can be minimized, alternative approaches to anesthesia planned, and all questions regarding the anesthesia procedure by the patient answered. Types of anesthesia include local, regional, epidural, general, moderate conscious sedation, or monitored anesthesia care (MAC). The anesthesia practitioner assumes responsibility for the post-anesthesia recovery period which includes all care

until the patient is released to the surgeon or another physician.

Anesthesiologists may personally perform anesthesia services or may supervise anesthesia services performed by a CRNA or AA. CRNAs may perform anesthesia services independently or under the supervision of an anesthesiologist. An AA always performs anesthesia services under the direction of an anesthesiologist. Anesthesiologists personally performing anesthesia services and non-medically directed CRNAs bill in a standard fashion in accordance with CMS regulations as outlined in the *Internet-Only Manuals (IOM), Medicare Claims Processing Manual*, Publication 100-04, Chapter 12, Sections 50 and 140. CRNAs and AAs practicing under the medical direction of anesthesiologists follow instructions and regulations regarding this arrangement as outlined in the above sections of the *Medicare Claims Processing Manual*.

B. Standard Anesthesia Coding

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

1. CPT codes 00100-01860 specify "Anesthesia for" followed by a general area of surgical intervention. CPT codes 01916-01933 describe anesthesia for diagnostic or interventional radiology procedures. Several CPT codes (01951-01953) describe anesthesia services for burn excision/debridement, obstetrical, and other procedures. CPT codes 99143-99150 describe moderate conscious sedation services.

Anesthesia services include, but are not limited to, preoperative evaluation of the patient, administration of anesthetic, other medications, blood, and fluids, monitoring of physiological parameters, and other supportive services.

Anesthesia codes describe a general anatomic area or service which usually relates to a number of surgical procedures, often from multiple sections of the *CPT Manual*. For Medicare purposes, only one anesthesia code is reported unless the anesthesia code is an add-on code. In this case, both the code for the primary anesthesia service and the anesthesia add-on code are reported according to *CPT Manual* instructions.

2. A unique characteristic of anesthesia coding is the reporting of time units. Payment for anesthesia services increases with time. In addition to reporting a basic unit value for an anesthesia service, the anesthesia practitioner reports anesthesia time. Anesthesia time is defined as the period during which an anesthesia practitioner is present with the patient. It starts when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the patient. Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service. In counting anesthesia time, the anesthesia practitioner can add blocks of time around an interruption in anesthesia time as long as the anesthesia practitioner is furnishing continuous anesthesia care within the time periods around the interruption.

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 anesthesia practitioner. 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 interval time and the recovery time are not to be included in the anesthesia time 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.

However, if it is medically necessary for the anesthesia practitioner to continuously monitor the patient during the interval time and not perform any other service, the interval time may be included in the anesthesia time.

3. It is standard medical practice for an anesthesia practitioner to perform a patient examination and evaluation prior to surgery. This is considered part of the anesthesia service and is included in the base unit of the anesthesia code. The evaluation and examination are not reported in the anesthesia time. If surgery is canceled, 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. (A non-medically directed CRNA may also report an E&M code under these circumstances if permitted by state law.)

Similarly, routine postoperative evaluation is included in the basic unit for the anesthesia service. If this evaluation occurs after the anesthesia practitioner has safely placed the patient under postoperative care, neither additional anesthesia time units nor evaluation and management codes should be reported for this evaluation. Postoperative evaluation and management services related to the surgery are not separately reportable by the anesthesia practitioner except when an anesthesiologist provides significant, separately identifiable ongoing critical care services.

Anesthesia practitioners other than anesthesiologists cannot report evaluation and management codes except as described above when a surgical case is canceled.

Anesthesia practitioners if permitted by state law may separately report significant, separately identifiable postoperative management services after the anesthesia service time ends. These services include, but are not limited to, postoperative pain management and ventilator management unrelated to the anesthesia procedure.

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 should not be reported in addition to CPT code 01996. Payment for management of epidural/subarachnoid drug administration is limited to one unit of service per postoperative day regardless of the number of visits necessary to manage the catheter per postoperative day (CPT definition). While an anesthesiologist or non-medically directed CRNA may be able to report 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 anesthesia practitioner 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 anesthesia practitioner. In certain circumstances critical care services are provided by the anesthesiologist. It is currently national CMS 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. Certain procedural services such as insertion of a Swan-Ganz catheter, insertion of a central venous pressure line, emergency intubation (outside of the operating suite), etc., are separately payable to anesthesiologists as well as non-medically directed CRNAs if these procedures are furnished within the parameters of state licensing laws.

4. Anesthesia HCPCS/CPT codes include all services integral to the anesthesia procedure such as preparation, monitoring, intra-operative care, and post-operative care until the patient is released by the anesthesia practitioner to the care of another physician. Examples of integral services include, but are not limited to, the following:

- Transporting, positioning, prepping, draping of the patient for satisfactory anesthesia induction/surgical procedures.
- Placement of external devices including, but not limited to, those for cardiac monitoring, oximetry, capnography, temperature monitoring, EEG, CNS evoked responses (e.g., BSER), doppler flow.
- Placement of peripheral intravenous lines for fluid and medication administration.
- Placement of airway (e.g., endotracheal tube, orotracheal tube).
- Laryngoscopy (direct or endoscopic) for placement of airway (e.g., endotracheal tube).
- Placement of naso-gastric or oro-gastric tube.
- Intra-operative interpretation of monitored functions (e.g., blood pressure, heart rate, respirations, oximetry, capnography, temperature, EEG, BSER, Doppler flow, CNS pressure).

- Interpretation of laboratory determinations (e.g., arterial blood gases such as pH, pO_2, pCO_2, bicarbonate, CBC, blood chemistries, lactate) by the anesthesiologist/CRNA.

- 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 diagnostic report must be present in the medical record.)

- Insertion of urinary bladder catheter.

- Blood sample procurement through existing lines or requiring venipuncture or arterial puncture.

The NCCI contains many edits bundling standard preparation, monitoring, and procedural services into anesthesia CPT codes. Although some of these services may never be reported on the same date of service as an anesthesia service, many of these services could be provided at a separate patient encounter unrelated to the anesthesia service on the same date of service. Providers may utilize modifier 59 to bypass the edits under these circumstances.

CPT codes describing services that are integral to an anesthesia service include, but are not limited to, the following:

- 31505, 31515, 31527 (Laryngoscopy) (Laryngoscopy codes describe diagnostic or surgical services.)

- 31622, 31645, 31646 (Bronchoscopy)

- 36000, 36010 - 36015 (Introduction of needle or catheter)

- 36400-36440 (Venipuncture and transfusion)

- 62310-62311, 62318-62319 (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 management 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 agent, CPT codes 62310-62319 should not be reported. Modifier 59 may be reported to indicate that the injection was performed for postoperative pain management, and a procedure note should be included in the medical record.

Pain management performed by an anesthesia practitioner after the postoperative anesthesia care period terminates may be separately reportable. However, postoperative pain management by the physician performing a surgical procedure is not separately reportable by that physician. Postoperative pain management is included in the global surgical package.

Example: A patient has an epidural block with sedation and monitoring for arthroscopic knee surgery. The anesthesiologist reports CPT code 01382 (Anesthesia for diagnostic arthroscopic procedures of knee joint). The epidural catheter is left in place for postoperative pain management. The anesthesiologist should not also report CPT codes 62311 (injection of diagnostic or therapeutic substance) or 01996 (daily management of epidural) on the date of surgery. 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 reported as CPT code 01382 and reasonably believes that postoperative pain is likely to be sufficient to warrant an epidural catheter, 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 than the surgery, modifier 59 would not be necessary. Effective January 1, 2004, daily hospital management of continuous epidural or subarachnoid drug administration performed on the day(s) subsequent to the placement of an epidural or subarachnoid catheter (CPT codes 62318-62319) may be reported as CPT code 01996.

- 64400-64530 (Nerve blocks)

- 67500 (Retrobulbar injection)
- 81000-81015, 82013, 82205, 82270, 82271(Performance and interpretation of laboratory tests)
- 91000, 91055, 91105 (Esophageal, gastric intubation)
- 92511-92520, 92543 (Special otorhinolaryngologic services)
- 92950 (Cardiopulmonary resuscitation)
- 92953 (Temporary transcutaneous pacemaker)
- 92960, 92961 (Cardioversion)
- 93000-93010 (Electrocardiography)
- 93040-93042 (Electrocardiography)
- 93303-93308 (Transthoracic echocardiography when utilized for monitoring purposes) However, when performed for diagnostic purposes with documentation including a formal report, this service may be considered a significant, separately identifiable, and separately reportable service.
- 93312-93317 (Transesophageal echocardiography when utilized for monitoring purposes) However, when performed for diagnostic purposes with documentation including a formal report, this service may be considered a significant, separately identifiable, and separately reportable service.
- 93318 (Transesophageal echocardiography for monitoring purposes)
- 93561-93562 (Indicator dilution studies)
- 93701 (Thoracic electrical bioimpedance)
- 93922-93981 (Extremity or visceral arterial or venous vascular studies) When performed diagnostically with a formal report, this service may be considered a

significant, separately identifiable, and if medically necessary, a separately reportable service.

- 94640(Inhalation/IPPB treatments)

- 94002-94004, 94660-94662 (Ventilation management/CPAP services) If these services are performed during a surgical procedure, they are included in the anesthesia service. These services may be separately reportable if performed by the anesthesia practitioner after post-operative care has been transferred to another physician by the anesthesia practitioner. Modifier 59 may be reported to indicate that these services are separately reportable. For example, if an anesthesia practitioner who provided anesthesia for a procedure initiates ventilation management in a post-operative recovery area prior to transfer of care to another physician, CPT codes 94002-94003 should not be reported for this service since it is included in the anesthesia procedure package. However, if the anesthesia practitioner transfers care to another physician and is called back to initiate ventilation because of a change in the patient's status, the initiation of ventilation may be separately reportable.

- 94664 (Inhalations)

- 94680-94690, 94770 (Expired gas analysis)

- 94760-94762 (Oximetry)

- 96360-96376 (Drug administration)

- 99201-99499 (Evaluation and management)

This list is not a comprehensive listing of all services included in anesthesia services.

C. Radiologic Anesthesia Coding

Medicare's anesthesia billing guidelines allow only one anesthesia code to be reported for anesthesia services provided in conjunction with radiological procedures. Radiological

Supervision and Interpretation (RS&I) codes may be applicable to radiological procedures being performed.

The appropriate RS&I code may be reported by the appropriate provider (e.g., radiologist, cardiologist, neurosurgeon, radiation oncologist). The RS&I codes are not included in anesthesia codes for these procedures.

Since Medicare anesthesia rules, with one exception, do not permit the physician performing a surgical or diagnostic procedure to separately report anesthesia for the procedure, the RS&I code(s) should not be reported by the same physician reporting the anesthesia service. Medicare rules allow physicians performing a surgical or diagnostic procedure to separately report medically reasonable and necessary moderate conscious sedation with a procedure unless the procedure is listed in Appendix G of the *CPT Manual.*

If a physician performing a radiologic procedure inserts a catheter as part of that procedure, and through the same site, a catheter is utilized for monitoring purposes, it is inappropriate for either the anesthesia practitioner or the physician performing the radiologic procedure to separately report placement of the monitoring catheter (e.g., CPT codes 36500, 36555-36556, 36568-36569, 36580, 36584, 36597).

D. Monitored Anesthesia Care (MAC)

Monitored Anesthesia Care (MAC) may be performed by an anesthesia practitioner who administers sedatives, analgesics, hypnotics, or other anesthetic agents so that the patient remains responsive and breathes on his own. MAC provides anxiety relief, amnesia, pain relief, and comfort. 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. CMS recognizes this type of anesthesia service as a payable service if medically reasonable and necessary.

Monitored anesthesia care includes the intraoperative monitoring by an anesthesia practitioner of the patient’s vital physiological signs in anticipation of the need for administration of general anesthesia or of the development of adverse reaction to the surgical procedure. It also includes the

performance of a pre-anesthesia evaluation and examination, prescription of the anesthesia care, administration of necessary oral or parenteral medications, and provision of indicated postoperative anesthesia care.

CPT code 01920 (Anesthesia for cardiac catheterization including coronary angiography and ventriculography (not to include Swan-Ganz catheter)) may be reported for monitored anesthesia care (MAC) in patients who are critically ill or critically unstable.

Issues of medical necessity are addressed by national CMS policy and local contractor coverage policies.

E. General Policy Statements

1. In this Manual many policies are described utilizing the term “physician”. Unless indicated differently the usage of this term does not restrict the policies to physicians only but applies to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and Medicare rules. In some sections of this Manual, the term “physician” would not include some of these entities because specific rules do not apply to them. For example, Anesthesia Rules and Global Surgery Rules do not apply to hospitals.

2. In 2010 the *CPT Manual* modified the numbering of codes so that the sequence of codes as they appear in the *CPT Manual* does not necessarily correspond to a sequential numbering of codes. In the *National Correct Coding Initiative Policy Manual for Medicare Services*, use of a numerical range of codes reflects all codes that numerically fall within the range regardless of their sequential order in the *CPT Manual.*

3. Physicians should not report drug administration CPT codes 96360-96376 for anesthetic agents or other drugs administered between the patient’s arrival at the operative center and discharge from the post-anesthesia care unit.

4. With limited exceptions Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical procedure when provided by the physician performing the procedure. The physician should not report CPT codes 00100-01999

or 64400-64530 for anesthesia for a procedure. Additionally, the physician should not unbundle the anesthesia procedure and report component codes individually. For example, introduction of a needle or intracatheter into a vein (CPT code 36000), venipuncture (CPT code 36410), drug administration (CPT codes 96360-96376) or cardiac assessment (e.g., CPT codes 93000-93010, 93040-93042) should not be reported when these procedures are related to the delivery of an anesthetic agent.

Medicare allows separate reporting for moderate conscious sedation services (CPT codes 99143-99145) when provided by the same physician performing a medical or surgical procedure except for those procedures listed in Appendix G of the *CPT Manual.*