Medicare Learning Network
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CMS
Information for Medicare Fee-For-Service Health Care Professionals

News Flash - National Provider Identifier (NPI) News – During this testing and implementation phase for the NPI, providers should pay close attention to information from health plans and clearinghouses to understand how claims are being processed and what providers should be doing to assure no disruption in payment. Providers should also ensure that the information they are submitting on a claim is what is being transmitted to each health plan by the billing vendors or clearinghouses who may be submitting the claims on their behalf. Additional information can be found at http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand/index.html on the CMS website.

MLN Matters Number: MM5618 revised
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Anesthesia Services Furnished by the Same Physician Providing the Medical and Surgical Service

Note: This article was updated on September 10, 2012, to reflect current Web addresses. This article was also revised on August 28, 2007, to reflect changes made to CR5618 on August 27, 2007. CR5618 was modified to include the correct Medicare Summary Notice message number for notifying beneficiaries when they are not liable for payment. The CR transmittal number, release date, and the Web address for accessing CR5618 were also changed. All other information remains the same.

Provider Types Affected

Physicians and other practitioners who bill Medicare carriers and/or Medicare Administrative Contractors (A/B MACs) for anesthesia services provided in conjunction with the performance of medical/surgical services.

Provider Action Needed

STOP – Impact to You

Physicians who both perform, and provide moderate sedation for, medical/surgical services will be paid for the conscious sedation consistent with CPT guidelines.

However, physicians who perform, and provide local or minimal sedation for, these procedures will not be paid separately for the sedation services.

CAUTION – What You Need to Know

The *Medicare Claims Processing Manual* (Publication 100-04) Chapter 12 (Physicians/Nonphysician Practitioners) Section 50A (General Payment) is being revised to be consistent with the pricing of the conscious sedation codes under the Medicare physician fee schedule payment system and CPT coding guidelines. In addition, a new section, 50L, explains the payment policy when the same physician performs both the medical/surgical service and the conscious sedation service, is added. Finally, Exhibit 1 that listed the base units by anesthesia code is deleted because it is out of date and the material is communicated to carriers and Medicare Administrative Contractors (known as A/B MACs) annually via the HCPCS tape.

GO – What You Need to Do

Make sure that your billing staffs are aware of these new payment policies that address the same physician performing both the medical/surgical service and the conscious sedation service.

Background

The continuum of complexity in anesthesia services (from least intense to most intense) ranges from 1) local or topical anesthesia, 2) moderate (conscious) sedation, 3) regional anesthesia, to 4) general anesthesia. Moderate sedation is a drug induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. It does not include minimal sedation, deep sedation or monitored anesthesia care.

CR 5618, from which this article is taken announces the revision of the anesthesia policy in the *Medicare Claims Processing Manual*, Chapter 12 (Physicians/Nonphysician Practitioners), Section 50A (General Payment), to be consistent with the pricing of conscious sedation codes under the Medicare physician fee schedule and CPT coding guidelines. It further announces:

1) The addition of a new Section (50L), that explains the payment policy if the same physician performs the medical/surgical service and the conscious sedation service; and

2) The deletion of Exhibit 1, that lists the base units by anesthesia code because it is out of date and the material is communicated to the carriers annually via the HCPCS tape.

Currently, section 50A instructs carriers and MACs not to allow separate payment for the anesthesia service performed by the same physician who furnishes the medical or surgical services (for example, there is no separate payment allowed for a surgeon's performance of a local or surgical anesthesia if the surgeon also performs the surgical procedure; or a psychiatrist's performance of the anesthesia service associated with the electroconvulsive therapy if the psychiatrist performs the electroconvulsive therapy).

The revised policy is: If the physician performing the procedure also provides moderate sedation for the procedure, then payment may be made for conscious sedation consistent with CPT guidelines; however, if the physician performing the procedure provides local or minimal sedation for the procedure, then no separate payment is made for the local or minimal sedation service.

Carriers and A/B MACS will not allow payment for codes 99148-99150 if any of these codes are performed on the same day with a medical/surgical service listed in Appendix G of CPT and the service is provided in a non-facility setting. A facility is defined in Chapter 23 Addendum of the *Medicare Claims Processing Manual* as one with a place of service code of 21, 22, 23, 24, 26, 31, 34, 41, 42, 51, 52, 53, 56, or 61.

Prior to 2006, Medicare did not recognize separate payment if the same physician both performed the medical or surgical procedure and provided the anesthesia needed for the procedure. The final physician fee schedule published in the Federal Register on November 21, 2005 included newly created codes (99143 to 99150) for moderate (conscious) sedation, which the CPT added in 2006.

Note: These codes have been assigned a status indicator of "C" under the Medicare physician fee schedule designating that these services are carrier priced. CMS has not established relative value units for these services.

Three of these codes (99143, 99144, and 99145) describe the scenario in which the same physician performing the diagnostic or therapeutic procedure provides the moderate sedation, and an independent trained observer's presence is required to assist in the monitoring of the patient's level of consciousness and physiological status. The other three codes (99148, 99149, and 99150) describe the scenario in which the moderate sedation is provided by a physician other than the one performing the diagnostic or therapeutic procedure.

CR 5618 presents some specific points that you should be aware of:

- CPT coding guidelines for conscious sedation codes instruct practices not to report Codes 99143 to 99145 in conjunction with the codes listed in CPT Appendix G. Your carrier or A/B MAC will follow the National Correct Coding Initiative, which added edits in April 2006 that bundled CPT codes 99143 and 99144 into the procedures listed in Appendix G (There are no edits for code 99145; it is an add-on-code and it is not paid if the primary code is not paid.).

- In the unusual event that a second physician (other than the one performing the diagnostic or therapeutic services) provides moderate sedation in the facility setting for the procedures listed in CPT Appendix G, the second physician can bill 99148 to 99150, but cannot report these codes when the second physician performs these services (on the same day as a medical/surgical service) in the non-facility setting.
- If an anesthesiologist or CRNA provides anesthesia for diagnostic or therapeutic nerve blocks or injections, and a different provider performs the block or injection, then the anesthesiologist or CRNA may report the anesthesia service using CPT code 01991. In this case, the service must meet the criteria for monitored anesthesia care. If the anesthesiologist or CRNA provides both the anesthesia service and the block or injection, then the anesthesiologist or CRNA may report the anesthesia service using the conscious sedation code and the injection or block. However, the anesthesia service must meet the requirements for conscious sedation and if a lower level complexity anesthesia service is provided, then the conscious sedation code should not be reported.
- There is no CPT code for the performance of local anesthesia, and as such, payment for this service is considered to be part of the payment for the underlying medical or surgical service. Therefore, if the physician performing the medical or surgical procedure also provides a level of anesthesia lower in intensity than moderate or conscious sedation (such as a local or topical anesthesia), then the conscious sedation code should not be reported and the carrier or A/B MAC will allow no payment.
- When denying claims, as appropriate under this policy, carriers and A/B MACs will use:
    - Medicare Summary Notice (MSN) message 16.8 when the service is bundled into the other service: "Payment is included in another service received on the same day;" In addition, the MSN (via MSN message 16.45) will note to the beneficiary that "You cannot be billed separately for this item or service. You do not have to pay this amount."
    - Claim adjustment reason code (CARC) 97: "Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated;"
    - Remittance advice remark code (RARC) M80: "We cannot pay for this when performed during the same session as another approved service for this beneficiary." Carriers and A/B MACs will note that the beneficiary is not liable for payment for claims denied as noted in the above MSN message.

- Finally, carriers and A/B MACs will adjust claims, brought to their attention, that were not processed in accordance with the Medicare physician fee schedule data base indicators assigned to the conscious sedation codes.

Additional Information

You can find the official instruction, CR 5618, issued to your carrier or A/B MAC by visiting http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1324CP.pdf on the CMS website. You will find updated Medicare Claims Processing Manual (100-04), Chapter 12 (Physicians/Non-physician Practitioners) as an attachment to that CR.

If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.