Chapter II
Anesthesia
CPT-4 00000 - 09999

A. Introduction

Anesthesia care conventionally includes all services rendered by an anesthesiologist and/or anesthetist to render an anatomical area subject to a surgical procedure in a state of analgesia/anesthesia so that surgical 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 the anesthesia five digit CPT-4 procedure code (00100-01860). Subsequent CPT-4 codes (01900-01922) are unique to anesthesia for interventional radiology. These codes specify "Anesthesia for..." followed by a general area of surgical intervention. Several CPT-4 codes (01990-01999) describe miscellaneous anesthesia services. The reporting of anesthesia services is 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 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-4 manual. For Medicare purposes, only one base code is billed. It is acceptable to bill the code that accurately describes the anesthesia for the procedure which has the highest base reimbursement.

2. Another unique characteristic of anesthesia coding is the reporting of time units for time spent delivering anesthesia. While some evaluation and management coding can be based on time, reimbursement is not directly incremental with increasing time as it is with anesthesia. Accordingly, in additional to billing a base code for an anesthesia service, the units of service reflecting the time of anesthesia attendance are included. Because of the variety of anesthesia services, time reporting can be confusing. The time measurement that is converted into the units of time service should reflect time spent directly monitoring a patient. Non-monitored interval time is not considered for conversion to time units.

For 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 the peri/retrobulbar injection for local anesthesia. Subsequently, an interval of 30 minutes or more may transpire during which time the patient does not require monitoring by an anesthesiologist/ anesthetist. After this period, monitoring will commence again for the cataract extraction and ultimately the patient will be released to recovery. The time that may be billed 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 time unit calculation. Similarly, if an intravenous catheter or arterial line is in place 30 minutes prior to a procedure, the time for completion of the procedures, if the procedure bundled into the anesthesia service, may be included; but the non-monitored time (in this example, 30 minutes) is not considered reportable time. If unusual services, not bundled into the anesthesia service, are required, the time spent delivering these services should not be included as reportable anesthesia time. In summary, if it is

medically necessary for the anesthesiologist/anesthetist to be in direct one to one observation, monitoring the patient, and not billing any other service, the time can be included.

When an anesthesiologist is supervising one or more anesthetists, similar parameters are to be followed (this is discussed in greater detail below). The anesthesiologist is supervising the anesthetist during the time that the anesthetist is delivering anesthesia; accordingly, the anesthesiologist's time reporting should never exceed the time of the supervised anesthetist (unless, of course, the anesthesiologist assumes control of the case and is no longer supervising an anesthetist).

3. It is standard medical practice for an anesthesiologist/ anesthetist to perform a patient evaluation prior to surgery. This is considered part of the anesthesia service and billing for a separate evaluation and management service is not appropriate if the only services provided were a pre-operative evaluation and orders. The time spent in performing the evaluation is not included in intraoperative service time. If surgery is cancelled, either because of other circumstances or because of findings on the pre-operative evaluation the anesthesiologist and cancellation occurs subsequent to the pre-operative 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 billed. Submission of an evaluation and management code in addition to an anesthesia code in the absence of surgery would be inappropriate.

Similarly, it is expected that a post-operative evaluation is included in 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. Post-operative 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 or extensive unrelated ventilator management. Management of epidural or subarachnoid drug administration (CPT-4 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 allowed in addition to

CPT-4 code 01996. Payment for management of epidural/subarachnoid drug administration is limited to one unit of service per post-operative day irrespective of the number of visits necessary to manage the catheter per post-operative day (CPT-4 definition). While an anesthesiologist or nurse anesthetist may be able to bill for this service, only one payment will be made per day. Post-operative critical care services are generally provided by the surgeon who is reimbursed under a global payment system and would not be billed by the anesthesiologist unless separate, medically necessary services are required that cannot be rendered by the surgeon.

In certain circumstances critical care services are provided by the anesthesiologist. It is currently national policy that nurse anesthetists cannot be reimbursed for evaluation and management services in the critical care area. In the case of anesthesiologists, the routine immediate post-operative care is not separately billed except as described above. Procedural services such as placement of lines, emergency intubation, etc.(outside of the operating suites) are payable to anesthesiologists as well as anesthetists.

4. One principle of CPT-4 coding convention is that if a service is routinely provided as part of a more comprehensive service, then it should be included in and be considered part of (or "bundled into") 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 billed:

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

- Placement of naso-gastric or oro-gastric tube.
- Routine intraoperative determination of monitored functions (blood pressure, heart rate, respirations, oximetry, capnography, temperature, EEG, BSER, doppler flow, CNS pressure).
- Interpretation of laboratory determinations (arterial blood gases such as pH, pO_2, pCO_2, bicarbonate, hematology, blood chemistries, lactate, etc.) by the anesthesiologist/ anesthetist.
- Nerve stimulation for determination of level of paralysis or localization of nerve(s).

When the following CPT-4 codes are billed with an anesthesia code, it will be assumed that these services are being billed as part of the anesthesia service and will be bundled into the primary anesthesia code. Because it is recognized that many of these procedures may occur on the same date of surgery and are not performed in the course of the anesthesia provision for the day, these codes will be separately paid only if accompanied by the "DS" modifier, indicating that the service rendered was independent of the anesthesia service.

- 31500 (Intubation)
- 31505, 31515, 31527 (Laryngoscopy)
- 31622, 31645, 31646 (Bronchoscopy)
- 36000 - 36015 (Introduction of needle)
- 36120-36140 (Introduction of needle)
- 36400-36440 (Venipuncture)
- 36600-36640 (Arterial puncture)
- 62278 - 62279 (When an epidural block is the nature of the anesthesia performed and another code is billed.) CPT-4 codes 62274-62279 may be billed on the date of surgery if performed for post-operative pain relief and not performed as the type of anesthesia provided. The "DS" modifier will indicate the latter situation 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-4 code 01382 for "Anesthesia for arthroscopic procedures of knee joint". The epidural catheter is left in place for post-operative pain management. The anesthesiologist may not also bill for CPT-4 codes 62278 (epidural injection) or 01996 (daily

management of epidural) on the date of surgery. The CPT-4 code 01996 may be billed 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-4 code 01382, and subsequently realized that post-operative pain was sufficient to warrant an epidural catheter, the CPT-4 code 62278-DS could be billed indicating that this was a separate service from the anesthesia service. The CPT-4 code 01996 could still only be billed on dates subsequent to the date of billing the CPT-4 code 62278-DS. If the epidural catheter was placed on a different date from the surgery, then the "DS" modifier would not be necessary.

- 63780, 63750 (Insertion of catheter)
- 64400-64565 (Nerve blocks)
- 67500 (Retrobulbar injection)
- 80002-80299, 81000-81099, 82000-87999, 88104-88199, 89050-89399 (Interpretation of laboratory tests)
- 90780-90799 (IV infusion - injections)
- 90835 (Narcosynthesis)
- 91000, 91055, 91105 (Esophageal, gastric intubation)
- 92511-92533, 92543 (Special otorhinolaryngologic services)
- 92585 (Electroencephalogram)
- 92950 (Cardiopulmonary resuscitation)
- 92953 (Temporary transcutaneous pacemaker)
- 92960 (Cardioversion)
- 93000-93018 (Cardiography)
- 93040-93042 (Cardiography)
- 93307-93325 (Echocardiography when displayed for monitoring purposes.) When performed for diagnostic purposes with documentation of a formal report, this could be considered a significant, separately identifiable, and separately reimbursable service.
- 93922-93981 (Extremity arterial venous studies) When performed diagnostically with a formal report, this could be considered a significant, separately identifiable, and if medically necessary a reimbursable service.
- 94640, 94650, 94651 (Inhalation/IPPB treatments)
- 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 reimbursable if performed after transfer out of post-anesthesia recovery to

a ward/ICU. The "DS" modifier would be necessary to signify that this was a separate service.

- 94664-94665 (Inhalations)
- 94680-94690 (Expired gas analysis)
- 94760-94770 (Oximetry)
- 99201-99499 (Evaluation and management)

(This is not a comprehensive list but includes those CPT-4 codes being address at present.)

When a physician performs a procedure and, incidentally, provides the anesthesia, the anesthesia for the procedure is not billed. (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 billed.

Anesthesia Code being billed by Anesthesiologist	Service not to be billed separately by Anesthesiologist
CPT-4 code 00530 (Anesthesia for transvenous pacemaker)	71090 (Diagnostic radiology) 76000 (Fluoroscopy)
CPT-4 code 00534 (Anesthesia for transvenous defibrillator)	71090 (Diagnostic radiology) 76000 (Fluoroscopy)
CPT-4 codes 00560-00580	71090 (Diagnostic radiology) 76000 (Fluoroscopy) 93501 (Right heart catheterization)
CPT-4 codes 01920-01921	71090 (Diagnostic radiology) 76000 (Fluoroscopy)

(This listing is not comprehensive but contains those CPT-4 codes being addressed at present.)

C. Radiologic Anesthesia Coding

In keeping with standard anesthesia billing guidelines for Medicare, only one anesthesia code may be billed 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 billed by the appropriate provider (radiologist, cardiologist, neurosurgeon, radiation oncologist, etc.). Accordingly, S&I codes are not "bundled" into anesthesia codes referable to these procedures; only the appropriate provider, however, may bill for S&I services.

CPT-4 code 01920 (Anesthesia for cardiac catheterization including coronary arteriography and ventriculography, not to include Swan-Ganz catheter) can be billed for monitored anesthesia care (MAC) in patients who are critically ill. 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/anesthetist or the physician performing the radiologic procedure to bill for placement of the monitoring catheter (e.g. CPT-4 codes 36488-36500).

D. Monitored Anesthesia Care

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 anesthetist. In essence, MAC involves patient monitoring in anticipation of 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 monitoring as a reimbursable 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 with regards to coding and reimbursement. The guidelines as promulgated previously apply equally to MAC. It is particularly important to note that only one anesthesia CPT-4 code is billed, and the time units billed represent only time where the patient was actually continuously monitored by a physician or anesthetist. Pre-operative and post-operative assessment follow standard anesthesia billing guidelines.

Issues of medical necessity are addressed by national and local contractor medical review policy.

E. Anesthesiologists and Physician Extenders (Anesthetists)

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. Section 4137, 4830, 5218, 8310). HCFA also recognizes anesthetists practicing under the direct supervision of anesthesiologists or practicing independently of anesthesiologists. Billing instructions and regulations regarding this arrangement are outlined in the Carriers' Manual as noted above.

A unique circumstance may arise in which an anesthesiologist performs a procedure (placement of temporary transvenous pacemaker, central line, epidural catheter, local block procedures, either for chronic pain or for subsequent procedure e.g. cataract, etc.) which is appropriately described by CPT-4 codes outside of the anesthesia section (00100-01999) and believes it to be medically necessary to perform MAC or general anesthesia. When the anesthesiologist performs the anesthesia in addition to the (non-anesthesia) procedure, the anesthesiologist is subject to the policy promulgated above, i.e., the anesthesia service is part of the global surgery package for the surgical procedure and is not separately billed.

In the event that the anesthesiologist has an anesthetist as an employee, a service for the anesthesia billed as "incident to" the (non-anesthesia) services provided by the anesthesiologist is bundled into the surgical service. If the anesthetist bills an anesthesia service under an independent provider number (as opposed

to being an employee of the anesthesiologist), the service is separately reimbursed however, the anesthesiologist may not bill a supervisory service for the anesthesia as this would be included in the global surgical package. The need for an anesthetist to provide the anesthesia services should be medically necessary.