Ten Steps to Coding
Anesthesia Services

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Disclaimer

The information in this presentation was current at the time the presentation was complied and does not include specific payer policies or contract language. Always consult CPT®, CMS, and your payers for specific guidance in reporting services. The views expressed in this presentation are simply my interpretations of information I have read, compiled and studied. Much of the information is directly from the AMA, ASA, AAPC, CMS literature and other reputable sources.
Objectives

• Coding
  – Identify resources and documentation needed to code anesthesia services
  – Establish a simple, structured process for coding anesthesia services

• Documentation Compliance
  – Identify common information needed to code anesthesia services missing from the medical record
  – Identify ASA documentation requirements anesthesia providers and coders need to know

Types of Anesthesia

• Topical infiltration
• Local anesthesia

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• Regional anesthesia
  – Peripheral nerve blocks
  – Epidural or spinal anesthesia
• Monitored anesthesia care (MAC)
• General anesthesia
Levels of Sedation

- Minimal sedation
- Moderate “conscious” sedation
- Deep sedation
- General sedation
- Monitored anesthesia care (MAC)

Who Makes the Rules?

- AMA – American Medical Association
  http://www.ama-assn.org/

- ASA – American Society of Anesthesiology
  http://www.asahq.org/
Resources Needed

• CPT® book
• ICD-9-CM book
• HCPCS book
• ASA Crosswalk
• ASA Relative Value Guide

ASA Resources

• Relative Value Guide (RVG)
  – Numeric value assigned to a procedure in relation to other procedures in terms of work and cost (similar to RVUs)
  – “Base Units”
• Anesthesia Crosswalk
  – Links surgical procedure(s) performed to the appropriate anesthesia service code
Documentation Needed

• Pre-anesthesia record completed by the anesthesia provider
• Anesthesia report completed by the anesthesia provider
• Post-anesthesia record completed by the anesthesia provider and the post-anesthesia care unit (PACU) team
• Surgeon’s operative report
What’s Included?

- Pre-operative and post-operative visit
- General or regional anesthesia and patient care
- Administration of fluids and/or blood
- Usual monitoring services (eg, ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry)

Bundled Services

- Laryngoscopy (31505, 31515, 31527)
- Bronchoscopy (31622, 31645, 31646)
- Introduction of needle or catheter (36000-36015)
- Venipuncture or transfusion (36400-35440)
- Blood sample procurement through existing lines
Bundled Services (cont.)

- Otorhinolaryngologic services (92511-92520, 92543)
- CPR (92950)
- Temporary transcutaneous pacemaker (92953)
- Cardioversion (92960)
- ECG/EKG (93000-93010)
- Cardiovascular Stress Tests (93015-93018)

Bundled Services (cont.)

- Retrobulbar injection (67500)
- Interpretation of lab tests (81000-81015, 82013, 82205, 82270, 82271)
- Injections and IV drug administration (96360-96375)
- Esophageal, gastric intubation (91000, 91055, 91105)

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13

14
Bundled Services (cont.)

- Injection of diagnostic or therapeutic substances (62310-62311, 62318-62319)
- Nerve blocks (64400-64530)
- Transesophageal echo (TEE) (93312-93318)

Each of the three services listed above may be separately reportable in certain circumstances. In those circumstances, modifier 59 should be appended to the CPT® code for the procedure(s) performed.

10 Steps

1. Determine the appropriate CPT® code(s) for the surgical procedure(s) performed.
2. Crosswalk the CPT® code(s) to the appropriate ASA code.
3. Determine the appropriate number of base units.
4. Determine the appropriate number of time units.
5. Assign the appropriate modifier to identify the anesthesia provider.
10 Steps (cont.)

6. Assign the appropriate modifier to identify MAC services, when appropriate.
7. Assign the appropriate physical status modifier.
8. If applicable, assign the appropriate qualifying circumstance code(s).
9. Determine the appropriate CPT® code(s) for any additional services or procedures performed.
10. Determine the total units for the anesthesia services.
Step 1: CPT® Code for Procedure

• Surgeon performs an excision of a benign tumor on the olecranon process
  – CPT® Code: 24120

Multiple Procedures

• Crosswalk all surgical procedures performed
• Select the anesthesia code with the highest base units value
• Only one ASA code is reported
• Report the total anesthesia time
Step 2: Crosswalk

- Surgeon performs an excision of a benign tumor on the olecranon process
  - CPT® Code: 24120

<table>
<thead>
<tr>
<th>CPT®</th>
<th>ASA</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>24120</td>
<td><strong>01740</strong></td>
<td>4+TM</td>
</tr>
</tbody>
</table>

Anesthesia for open or surgical arthroscopic procedures of the elbow; not otherwise specified

Multiple Procedures Example

- Procedures Performed:
  - Closed treatment of proximal fibula or shaft fracture
    - CPT® Code: 27780
    - ASA Crosswalk: 01462
    - ASA Base Units: 3
  - Revision of total hip arthroplasty
    - CPT® Code: 27130
    - ASA Crosswalk: 01215
    - ASA Base Units: 10
Multiple Crosswalk Options

- Procedure:
  - Coronary artery bypass, vein only (33510)
- ASA Crosswalk Options:
  - 00562 Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator, age 1 or older for all non-coronary bypass procedures or for re-operation for coronary bypass more than 1 month after original operation
    • (Base = 20)
  - 00566 Anesthesia for direct coronary artery bypass grafting; without pump oxygenator
    • (Base = 25)
  - 00567 Anesthesia for direct coronary artery bypass grafting; with pump oxygenator
    • (Base = 18)

Step 3: Base Units

ASA-RVG Base Unit Exceptions

- Procedures of the head, neck, or shoulder girdle requiring field avoidance
- Procedures performed in a position other than supine or lithotomy

For either of the above circumstances, a minimum base unit of 5 should be used.
Patient Positions

Step 4: Time Units

Anesthesia Time

- **Begins**: When the anesthesia provider prepares the patient for the induction of anesthesia in the operating room or equivalent area.
- **Ends**: When the anesthesia provider is no longer in personal attendance (patient is safely placed under post-operative supervision).
Step 4: Time Units (cont.)

- AMA and ASA recommend that 1 unit of time is equal to 15 minutes of anesthesia time.
  - Time is rounded up to the next unit after 7 ½ minutes is reached.

- Some carriers do not follow the above recommendation. Refer to your local payer contracts and policies for specific guidance for reporting time.

Step 5: Anesthesia Provider

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA</td>
<td>Anesthesia services performed personally by anesthesiologist</td>
</tr>
<tr>
<td>AD</td>
<td>Medical supervision by a physician: more than four concurrent anesthesia procedures</td>
</tr>
<tr>
<td>QK</td>
<td>Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals</td>
</tr>
<tr>
<td>QY</td>
<td>Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist</td>
</tr>
<tr>
<td>QX</td>
<td>CRNA service: with medical direction by a physician</td>
</tr>
<tr>
<td>QZ</td>
<td>CRNA service: without medical direction by a physician</td>
</tr>
</tbody>
</table>
Medicare and Medical Direction

1. Perform pre-anesthetic exam and evaluation
2. Prescribe the anesthesia plan
3. Personally participate in the most demanding procedures in the anesthesia plan
4. Ensures procedures that are not personally performed are performed by a qualified individual
5. Monitors the course of anesthesia in frequent intervals
6. Remains physically present and available for emergencies
7. Provides indicated post-operative care

Step 6: MAC Services

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>QS</td>
<td>Monitored anesthesia care service</td>
</tr>
<tr>
<td>G8</td>
<td>Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure</td>
</tr>
<tr>
<td>G9</td>
<td>Monitored anesthesia care for patient who has history of severe cardiopulmonary condition</td>
</tr>
</tbody>
</table>

If a service is intended to be MAC and at any point the patient is unable to control their own airway, the service is no longer considered a MAC service and should be reported as general anesthesia.
Step 7: Physical Status

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>Base Unit Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>A normal health patient</td>
<td>0</td>
</tr>
<tr>
<td>P2</td>
<td>A patient with mild systemic disease</td>
<td>0</td>
</tr>
<tr>
<td>P3</td>
<td>A patient with severe systemic disease</td>
<td>1</td>
</tr>
<tr>
<td>P4</td>
<td>A patient with severe systemic disease that is a constant threat to life</td>
<td>2</td>
</tr>
<tr>
<td>P5</td>
<td>A moribund patient who is not expected to survive without the operation</td>
<td>3</td>
</tr>
<tr>
<td>P6</td>
<td>A declared brain-dead patient whose organs are being removed for donor purposes</td>
<td>0</td>
</tr>
</tbody>
</table>

Step 8: Qualifying Circumstances

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Base Unit Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>+99100</td>
<td>Anesthesia for patient of extreme age, younger than 1 year and older than 70 (List separately in addition to code for primary anesthesia procedure)</td>
<td>1</td>
</tr>
<tr>
<td>+99116</td>
<td>Anesthesia complicated by utilization of total body hypothermia (List separately in addition to code for primary anesthesia procedure)</td>
<td>5</td>
</tr>
<tr>
<td>+99135</td>
<td>Anesthesia complicated by utilization of controlled hypotension (List separately in addition to code for primary anesthesia procedure)</td>
<td>5</td>
</tr>
<tr>
<td>+99140</td>
<td>Anesthesia complicated by emergency conditions (List separately in addition to code for primary anesthesia procedure)</td>
<td>2</td>
</tr>
</tbody>
</table>
99100 Exceptions

- 00326 – Anesthesia for all procedures on the larynx and trachea in children younger than 1 year of age
- 00561 – Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator, younger than 1 year of age

99100 Exceptions (cont.)

- 00834 – Anesthesia for hernia repairs in the lower abdomen not otherwise specified, younger than 1 year of age
- 00836 – Anesthesia for hernia repairs in the lower abdomen not otherwise specified, infants younger than 37 weeks gestational age at birth and younger than 50 weeks gestational age at time of surgery
Step 9: Additional Procedures

- Insertion of central venous catheter (36555-36558, 36568-36569)
- Insertion of an intra-arterial catheter (36620-36625)
- Insertion of Swan-Ganz (93503)
- Transesophageal Echocardiography (TEE) (93312-93318)
- Procedures performed for post-operative pain management

Line Placements

- When was the line placed?
- Who placed the line?
  - Reportable by the anesthesia provider:
    - The anesthesia provider
  - Not reportable by the anesthesia provider:
    - The surgeon
    - Another provider
- Was the CVP used to thread the Swan-Ganz catheter?
  - If so, only the Swan-Ganz is separately reportable
- How many lines are there?
Transesophageal Echocardiography

• Reportable by the anesthesia provider:
  – When performed for diagnostic or therapeutic purposes and supported by the documentation
  – Modifier 59 should be appended to the CPT® code for the TEE

Post-Operative Pain Management

• Epidurals
  – If epidural is route of administration for anesthesia, post-operative pain management is not separately reportable
  – When separately reportable
    • Based on spinal region
    • Two types
      – Single Injection (62310 – 62311)
        » 01996 is not appropriate
      – Continuous Infusion or Intermittent Bolus (62318-62319)
        » Include catheter placement
        » Append modifier 59
        » Can report 01996 for subsequent daily hospital management
Post-Operative Pain Management (cont.)

• Nerve Blocks
  – If epidural is route of administration for anesthesia, post-operative pain management is not separately reportable
  – When separately reportable
    • Based on the nerve being blocked
    • Single Injection
    • Continuous Infusion by Catheter
      – Brachial plexus, sciatic nerve, femoral nerve, lumbar plexus

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Step 10: Total Anesthesia Units

**Medicare**
Base Value + Time Units = Total Units

**Other Payers***
Base Value + Time Units + Modifying Units = Total Units

*Verify your payers’ policies and contracts for specific guidance for proper determination of calculating units.
Exceptions

Anesthesia for Obstetric Services
Anesthesia for Burn Excisions or Debridement
Anesthesia for Obstetrics

- Base units plus time units (insertion through delivery), subject to a reasonable cap
- Base units plus one unit per hour for neuraxial analgesia management plus direct contact time (insertion, management of adverse effects, delivery, removal)
- Incremental time-based fees (eg, 0<2 hrs, 2-6 hrs, >6 hrs)
- Single fee

Anesthesia for Burn Excisions or Debridement

- Second- or third-degree burns treated during anesthesia and surgery
- Based on total body surface area (TBSA)
  - 01951: less than 4% total body surface area
  - 01951: 4% to 9% total body surface area or part thereof
  - +01953: each additional 9% total body surface area or part thereof
Anesthesia Documentation & Compliance

Anesthesia Team

- Anesthesiologist
- Anesthesiology Fellow
- Anesthesiology Resident
- Nurse Anesthetist
- Anesthesiologist Assistant
- Student Nurse Anesthetist
- Anesthesiologist Assistant Student
Safe Conduct

• Anesthesiologist directing the team is responsible for:
  – Management of personnel
  – Preanesthetic evaluation of the patient
  – Prescribing the anesthetic plan
  – Management of the anesthetic
  – Postanesthesia care
    • Postanesthetic complications
  – Anesthesia consultation

Preanesthesia Documentation

• Patient interview, including
  – Patient identification
  – Procedure identification
  – Verification of admission status
  – Medical history
  – Anesthetic history
  – Medication and allergy history
  – NPO status
  – Assess aspects of patient’s physical condition that might affect decisions regarding perioperative risk and management
Preanesthesia Documentation (cont.)

- Appropriate physical examination, including
  - Vital signs
  - Airway assessment
- Review of objective diagnostic data
- Review of available medical record
- Formulation of the anesthetic plan and discussion of the risks and benefits of the plan (including discharge issues when indicated) with the patient or the patient’s legal representative and/or escort
- Records an assessment (diagnosis)
- Documentation of appropriate informed consent(s)

Preanesthesia Documentation (cont.)

- When applicable/indicated
  - Medical consultations
  - Assignment of ASA physical status, including emergent status when applicable
  - Appropriate premedication and prophylactic antibiotic administrations
Preanesthesia Documentation (cont.)

- If the patient is a minor or is unable to communicate, this should be reflected in the documentation as should the source of the information obtained.

Intra-operative Documentation

**Time-based record of events, including**

- Immediate review prior to initiation of anesthetic procedures
  - Patient re-evaluation
  - Re-verification of NPO status
  - Check of equipment
  - Check of drugs supply
  - Check of gas supply
Intra-operative Documentation (cont.)

- Technique used
- Patient position(s)
- Any unusual events during the administration of anesthesia
- Status of the patient at the conclusion of anesthesia

Intra-operative Documentation (cont.)

- Monitoring of the patient
  - Oxygenation
  - Ventilation
  - Circulation
  - Body Temperature
- Doses of drugs and agents used
  - Times of administration
  - Routes of administration
  - Any adverse reactions
Intra-operative Documentation (cont.)

- Type of IV fluids used*
  - Amounts of IV fluids used
  - Times of IV fluid administration
- Intravenous/Intravascular lines inserted
  - Technique for insertion
  - Location
- Airway devices inserted
  - Technique for insertion
  - Location

*IV fluids includes blood and blood products

Postanesthesia Documentation

- Anesthesia provider
  - Patient evaluation on admission to postanesthesia care unit (PACU)
- Anesthesia provider/PACU Nurse
  - Patient evaluation on discharge from PACU
  - Any unusual events during the administration of anesthesia
  - Postanesthesia visits
Postanesthesia Documentation (cont.)

- Anesthesia provider/PACU Nurse
  - Time-based record of
    - Vital signs
    - Level of consciousness
    - Drugs administered
      - Dosage
      - Route of administration
      - Type of IV fluids used
      - Amounts of IV fluids used

Resources Utilized

- 2011 CPT® Professional Edition
- 2011 ICD-9-CM
- 2011 HCPCS Level II
- 2011 ASA Relative Value Guide
- 2011 ASA Crosswalk
- ASA Standards Guidelines and Statements
  - The Anesthesia Care Team (2009)
  - Documentation of Anesthesia Care (2008)
  - Basic Standards for Preanesthesia Care (2009)
  - Standards for Postanesthesia Care (2009)
QUESTIONS?

Chandra Stephenson, CPC, CPC-H, CPC-I, CPMA, CHA, CANPC, CEMC, CFPC, CIMC, COSC
clsteph2@gmail.com