

### ANESTHESIA

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#### Anesthesia Coding

CPT codes 00100-01999 are utilized to report anesthesia services. Anesthesia codes may be reported by any physician, but generally the codes are used to report services rendered by anesthesiologists, CRNA's and AA's. Per CPT instruction, these services include general, regional, supplementation of local anesthesia, or other supportive services provided to patients during any procedure.

When reporting anesthesia, the anesthetic drugs are reported separately from the administration of the anesthesia. Supplies may or may not be reported separately depending on how the hospital charge master is set up and whether these services are included or bundled into the anesthesia procedure charge or not.

The anesthesia CPT codes are reported by body area where surgery is being performed as follows:

**Head** 00100-00222

**Neck** 00300-00352

**Thorax** 00400-00474

**Intrathoracic** 00500-00580

**Spine and Spinal Cord** 00600-00670

**Upper Abdomen** 00700-00797

**Lower Abdomen** 00800-00882

**Perineum** 00902-00952

**Pelvis (excludes hip)** 01112-01173

**Upper Leg (excludes knee)** 01200-01274

**Knee and Popliteal Area** 01320-01444

**Lower Leg (below knee including ankle and foot)** 01462-01522

**Shoulder and Axilla** 01610-01680

**Upper Arm and Elbow** 01710-01782

**Forearm, Wrist and Hand** 01810-01860

**Radiological Procedures** 01916-01936

**Burn Excisions or Debridement** 01951-01953

**Obstetric** 01958-01969

**Other Procedures** 01990-01999

Anesthesia may be administered by a physician performing a surgery, an anesthesiologist, a Certified Registered Nurse Anesthetist (CRNA) or an anesthesiologist assistant (AA).

If reporting anesthesia services under the anesthesiologist's tax ID number, specific supervision requirements must be met for anesthesia administered by a CRNA and/or an AA. CRNA's may report anesthesia services under their own tax ID number as well if they choose to obtain one. Payment and supervision requirements for CRNA's and AA's are dependent on the state regulations and individual payer requirements.

CMS describes anesthesiologist assistants and CRNA's as follows:

An **anesthesiologist assistant** is a person who:

- Is permitted by state law to administer anesthesia; and
- Has successfully completed a six-year program for anesthesiologist's assistants of which two years consist of specialized academic and clinical training in anesthesia.

A **CRNA** is a registered nurse who is licensed by the state in which the nurse practices and who:

- Is currently certified by the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists; or
- Has graduated within the past eighteen months from a nurse anesthesia program meeting the standards of the Council of Accreditation of Nurse Anesthesia Educational Programs and awaits initial certification.

CRNAs and AAs may bill Medicare directly for their services or have payment made to an employer or an entity under which they have a contract. This could be a hospital, physician or ambulatory surgical center.

**Supervision requirements** for anesthesia administration include personally performed supervision, performed under supervised medical direction or medically supervised. These categories are further defined below.

**Personally performed** is defined by the following guidelines:

- ✓ The physician personally performed the entire anesthesia service alone;
- ✓ The physician is a teaching physician and is involved with one anesthesia case with a resident;
- ✓ The physician is continuously involved in a single case involving a student nurse anesthetist; or
- ✓ The physician and the non-medically directed CRNA (or Anesthesiologist Assistant) is involved in one anesthesia case and the services of each are found to be medically necessary.

**Medical directed supervision** occurs if the physician medically directs qualified individuals in two, three, or four concurrent cases and the physician performs the following activities:

- ✓ Performs a pre-anesthesia examination and evaluation;
- ✓ Prescribes the anesthesia plan;
- ✓ Personally participates in the most demanding procedures of the anesthesia plan, including induction and emergence, if applicable;
- ✓ Ensures that any procedures in the anesthesia plan that he/she does not perform are performed by a qualified anesthetist;
- ✓ Monitors the course of anesthesia administration at frequent intervals;
- ✓ Remains physically present and available for immediate diagnosis and treatment of emergencies; and
- ✓ Provides indicated post-anesthesia care.

The physician can medically direct two, three, or four concurrent procedures involving qualified individuals, all of whom could be CRNAs, AAs, interns, residents or combinations of individuals. The medical direction rules apply to cases involving student nurse anesthetists if the physician directs two concurrent cases, each of which involves a student nurse anesthetist, or the physician directs one case involving a student nurse anesthetist and another involving a CRNA, AA, intern or resident. For medical direction services, the

physician must document in the medical record that he or she performed the pre-anesthetic exam and evaluation. Physicians must also document that they provided indicated post-anesthesia care, were present during some portion of the anesthesia monitoring, and were present during the most demanding procedures, including induction and emergence, if applicable.

### **Medically Supervised**

When an anesthesiologist is involved in rendering more than four procedures concurrently or is performing other services, except as outlined previously while directing the concurrent procedures, the anesthesia services are considered medically supervised.



### **Anesthesia Categories**

The three main categories of anesthesia include general, MAC and regional anesthesia.

**General anesthesia** – anesthesia administered that renders the patient completely unconscious. The patient is unaware of their surroundings and they have no sensation. General anesthesia is administered primarily through mask, nose tube or intravenously.

### **Major Anesthesia Categories**

#### **MAC (Monitored Anesthesia Care)**

Monitored Anesthesia Care (MAC) is administered intravenously and is used to relax a patient during the performance of more minor procedures. These procedures do not require general anesthesia. Examples include colonoscopies and surgical biopsies. In addition to administering MAC, a local anesthetic may be used to numb the surgical site.

#### **MCS (Moderate Conscious Sedation)**

Moderate conscious sedation (previously referred to as conscious sedation) is a depressed level of consciousness where the patient is conscious and able to respond to verbal commands and is able to maintain breathing on their own. Code series 99151-99157 are used to report MCS services.

MCS services include assessment of the patient, establishment of IV access, administration of agent(s), maintenance of sedation, monitoring of oxygen saturation, heart rate, blood pressure, and recovery.

Minimum time requirements must be met in order to report MCS. In October 2011, CPT Assistant indicated that the CPT standard for time measurement does apply to the moderate (conscious) sedation codes 99151-99157. Per CPT, A unit of time is attained when the midpoint has been passed. For example, an hour is attained when 31 minutes have elapsed (more than midway between zero and sixty minutes).

In 2017, CPT removed the moderate conscious symbol and changed rules for the workload RVU components related to reimbursement for these services when performed by someone other than the surgeon performing the service for which MCS is administered. The descriptions for the codes have been updated as well to include 15-minute increments and codes for surgeon or other provider performing the service other than the surgeon. We will address these changes in more detail in chapter 11 when we review the MCS codes in the medicine section where these codes are found.

### **Moderate Sedation**

**Regional anesthesia** – administered via injection within the region the surgery is being performed. The injection is given within the group of nerves (or clusters) of the surgical area. The patient may be awake during regional anesthesia; however, there is no pain or visualization of the surgery taking place. Examples of regional anesthetic include a spinal and epidural administered anesthetic. Regional anesthesia is typically used for gynecologic (e.g. hysterectomies) and urologic (e.g. prostate) surgeries, as well as surgeries of the lower extremities (e.g. knee surgery).

### **Types of Regional Anesthesia**

**Axillary Nerve Block** – Local anesthetic is injected around the nerve that passes through the axilla (armpit) from the shoulder to the arm to numb the feeling in your arm and hand. This is typically used for surgery of the elbow, forearm, wrist, or hand.

**Interscalene Nerve Block** – Local anesthetic is injected around the nerve block in the neck used to numb the shoulder and arm. This is typically used for surgery of the shoulder and upper arm.

**Femoral Nerve Block** – Local anesthetic is injected around the nerve block in the upper thigh/groin area to numb the leg from the hip to the knee. This is typically used for surgery of the upper leg, hip or knee.

**Ankle Block** – Local anesthesia is injected around the ankle to block the five nerve branches that supply sensation to the foot. As the name indicates, this is used for surgery of the ankle, foot or toes.

**Bier Block** – Local anesthetics are injected intravenously to numb a limb, typically the arm, and then a tourniquet is applied to prevent the anesthetic from leaving the area. This is typically used on surgeries that last less than an hour on the hand or arm.

**Local anesthesia** – anesthesia administered into the tissue in the area where surgery is performed. The local anesthetic is provided for minor procedures only and would not be used when performing major procedures. When administered, local anesthetic is not separately reported and is bundled into the surgery procedure code reported.

Anesthesia services include the usual preoperative and postoperative visits, administration of fluids and/or blood and usual monitoring services including blood pressure monitoring, electrocardiogram monitoring, oximetry, capnography, and mass spectrometry. These services are not reported separately. Unusual monitoring such as intra-arterial, central venous, and Swan-Ganz catheterization are reported in addition to the anesthesia services.

The amount of time that a patient is under anesthesia is reported in addition to the procedure codes reported for anesthesia services. The **reporting of time** for anesthesia begins when the anesthesiologist begins to prepare the patient for induction of anesthesia in the operating room (or other area) and ends when the anesthesiologist is no longer attending to the patient and when the patient is safely put under postoperative care.

Prior to January 2012, anesthesia time was reported by units; however, with the implementation of HIPAA requirements for electronic claims submission (5010), the unit-based time reporting method was changed to a minute-based time reporting method. The following press release from Washington Alerts describes the change and how the formula for determining anesthesia time will become universal.

Washington Alerts Press Release

### ***New Regulation Regarding Reporting of Anesthesia Time***

*Monday, August 01, 2011*

*As part of the transition to the 5010 HIPAA electronic claims standards, a universal system for reporting anesthesia time to all payers will go into effect January 1, 2012. This new standard will require all anesthesia time to be reported in minutes instead of units - the current norm for some commercial (private) payers.*

*For more than a decade, ASA was able to successfully prevent this change through its lobbying activity; however, the change is now going into effect. During each stage of the lobbying on this issue, ASA has consistently communicated with members that, "No one should be surprised at further attempts by X12N and the payers to eliminate our ability to round anesthesia time." (American Society of Anesthesiologists Newsletter, June 2003, Volume 67, Number 6).*

*This change may result in some payers attempting to move from a full unit to a fractional unit payment system. A move from a full unit to fractional unit system would likely benefit some and cost other anesthesia providers depending on when the individual contracts permit rounding to the next unit. The bottom line is that any changes to commercial payment contracts will have to be negotiated between anesthesiologists and commercial providers. Anesthesiologists should be aware of this change when negotiating contracts with payers. The change to the reporting standard does not prohibit payers/providers contracts from rounding to the nearest whole unit when determining payments.*

### **Anesthesia Modifiers**

Physical status modifiers are utilized when coding anesthesia services to distinguish levels of complexity of the anesthesia provided based on the condition of the patient.

**Physical status** modifiers are represented by the letter P followed by a single digit from 1-6.

These levels are described as follows:

- P1** Normal healthy patient
- P2** Patient with mild systemic disease
- P3** Patient with severe systemic disease
- P4** Patient with severe systemic disease that is a constant threat to life
- P5** A moribund patient who is not expected to survive without the operation
- P6** A declared brain-dead patient whose organs are being removed for donor purposes

**EXAMPLE:** 01120 P1

Anesthesia modifiers are also utilized to distinguish **who** performed the anesthesia service. These modifiers should be reported in the primary modifier field.

- AA** Anesthesia services performed personally by an anesthesiologist
- AD** Medical supervision by a physician; more than four concurrent anesthesia procedures.
- QK** Medically directed by a physician; two, three or four concurrent procedures.
- QY** Anesthesiologist medically directs one CRNA
- QX** CRNA service; with medical direction by a physician
- QZ** CRNA service; without medical direction by a physician

Additional anesthesia modifiers may be used as second position modifiers to further clarify modified or **unique circumstances** as it relates to anesthesia administration.

- QS** Monitored anesthesia care service
- 23** Unusual anesthesia (appropriate documentation must accompany any claims submitted utilizing the -23 modifier).
- 32** Mandated services
- 47** Anesthesia by surgeon
- 53** Discontinued procedure
- 59** Distinct procedural service

- 76 Repeat Procedure by Same Physician on Same Date of Service
- 77 Repeat Procedure by Different Physician on Same Date of Service
- G8 Monitored anesthesia care (an informational modifier, does not affect reimbursement)
- G9 MAC for at risk patient (an informational modifier, does not affect reimbursement)

**Qualifying circumstances codes** are reported to describe anesthesia provided under difficult circumstances such as unusual risk factors. These codes are not reported independently but as additional procedures representing these difficult circumstances. These additional codes are as follows:

99100 Anesthesia for patient of extreme age, under one year or over seventy

99116 Anesthesia complicated by utilization of total body hypothermia

99135 Anesthesia complicated by utilization of controlled hypotension

99140 Anesthesia complicated by emergency conditions (specify)

The anesthesia procedures codes 00100-01999 would be reported first and the qualifying circumstance code would be reported under the anesthesia code.

**Example:** *75-year-old patient is administered anesthesia for a removal of a large mass on the skin of the neck. Report codes 00300 P1 Anesthesia for all procedures on integumentary system of neck, including subcutaneous tissue and 99100 Anesthesia for patient of extreme age, under one year or over seventy.*

\*Note that anesthesia licensing requirements are determined by state and that reimbursement guidelines do not necessarily meet the same criteria as state licensure requirements.

**Pain management services** are frequently performed by anesthesiologists in clinic settings. Injections for pain management are also reported in the CPT surgery section utilizing category I 62XXX and 64XXX code series. There are also new technology category III injection codes for pain management. Drugs are reported separately utilizing HCPCS Level II J codes. The 2019 CPT code categories for these codes is listed below.

**Epidural Injection Procedures and Diagnostic Selective Nerve Root Block** includes codes 62320-62323, 64479-64484, and 0228T-0231T.

**Paravertebral Facet Injection/Nerve Block/Neurolysis** includes codes 64490-64495, 64633-64640, and 0213T-0218T.

**Regional Sympathetic Nerve Block** includes codes 64510-64520.

**Sacroiliac Joint Injection** includes CPT code 27096 and HCPCS Level II code G0260.

**Spinal Cord Stimulators** includes CPT codes 63650-63688 and HCPCS Level II codes C1767-C1822 and L8680-L8688 (neurostimulator equipment)

These pain management codes will be discussed in more detail in this manual in chapters covering Surgery procedures and HCPCS Level II coding system.



For more information on Anesthesia coding guidelines and rules for practitioners visit <http://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center.html>.  
General anesthesia information can be found at <http://www.asahq.org>.