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Part B Insider (Multispecialty) Coding Alert

Invasive Line Placement: Separate Billing for Invasive Line Placement Requires Documentation

Check state laws, carrier policies for 36555, 36620, and 93503

If your anesthesiologist places an invasive line before or during an operation, that's a lot of extra work that she should get paid for. But unless the anesthesia record supports a claim for an arterial line, Swan-Ganz catheter, or central venous pressure line, you may be out of luck.

The most frequent problem with separate payment for invasive line placement comes with billing for arterial line (A-line) placement during a bypass operation, says **Lee Broadston** with BCS Consult Inc. in Waconia, Minn. It seems that some payers believe A-line placement is included in a bypass, but this isn't supported by any Medicare policies.

As long as the A-line placement is separately laid out in the anesthesia record, including placement time, location, needle size and who placed it, the carrier should cover it. But if your record doesn't include that information, you're in deep trouble, Broadston adds. Sometimes you can find a mention of a Swan-Ganz or central venous pressure placement in the operative report, but you can't count on that.

To report an A-line, use CPT code 36620 (Arterial catheterization or cannulation for sampling, monitoring or transfusion; percutaneous), and to report a Swan-Ganz catheter use 93503 (Insertion and placement of flow directed catheter for monitoring purposes). The 2004 updates to the CPT guides replace the old CVP line codes (36488-36491) with new codes: 36555-36556, 36568-36569, 36580 and 36584, says **Cathy Steiner** with the Medical College of Wisconsin in Milwaukee.

One major difference between Medicare and some other payers: Medicare generally doesn't require a modifier such as -59 (Distinct procedural service) for separate line placement, says **Kelly Dennis** with Perfect Office Solutions in Leesburg, Fla.

Generally, you won't use an A-line, Swan-Ganz or CVP just for monitoring, but for procedures that require additional access, Dennis says. For example, Swan-Ganz catheterization involves threading a catheter into the right side of the heart to obtain diagnostic information on the heart's functioning and provide non-stop monitoring of heart functioning in critically ill patients.

Usually, the doctor will place these invasive lines either directly before or during the surgery, "in anticipation of either needing to give additional fluids or some extra monitoring," Dennis says.

You should make sure to document everything about the line placement, including who placed it. Sometimes doctors will "check off a box, but they really should be putting down who placed the line [and] whether it was the physician," Dennis says.

In some states, nurse-anesthetists are allowed to place an invasive line and bill for it separately, but other states forbid this, Dennis says. Either way, the documentation should show that the CRNA, not the physician, placed the line.

If the physician threads a CVP through a Swan-Ganz or vice versa, you don't get to bill for both lines, Dennis says. You usually bill for the higher of the two codes, but it depends on the record. But if the physician placed the CVP and then threads the Swan-Ganz through it a day later, he can bill for both separately.

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If an anesthesiologist places the CVP, Swan-Ganz or A-line, she should bill for it using a surgical code and list the Type of Service as "2" for surgical, not "7" for anesthetic, Broadston says.

You don't report anesthesia time with line placement because these are considered flat-fee procedures, Dennis says. In fact, some payers don't want anesthesiologists to bill for separate anesthesia time while placing an invasive line. They reason that the physician can't be doing both things at once. But "a lot of states don't care if you bill for line placement while your anesthesia clock is running," she adds.

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