Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Anesthesiologists Could Collect Extra Units for Field Avoidance

Even if Medicare won't pay, other payers often do.

Seeing a note of "field avoidance" in your anesthesia provider's notes might lead to additional reimbursement. Here's what to look for in order to determine whether the technique might boost your bottom line.

Grasp the Field Avoidance Basics

The term "field avoidance" basically means the anesthesiologist doesn't have direct access to the patient's airway during surgery. Whether it's due to the nature of the case itself or because the surgeon has the patient in a different position than normal, field avoidance makes the case a higher risk for the anesthesiologist.

If the documentation supports field avoidance, the anesthesiologist can charge a minimum of 5 base units for the procedure. How? By taking a lower-base procedure code and adding 1 or 2 units for a total of 5 because of field avoidance.

The American Society of Anesthesiologists' Relative Value Guide (RVG) addresses the issue in its Anesthesia Guidelines section: "Any procedure around the head, neck or shoulder girdle, requiring field avoidance, or any procedure requiring a position other than supine or lithotomy, has a minimum Basic Value of 5 regardless of any lesser basic value assigned to such procedure in the body of the Relative Value Guide."

Double Check the Procedure

Certain procedures are virtually always done the same way, so the anesthesiologist or CRNA knows beforehand that the case will probably involve field avoidance. Cases falling into this category involve the surgeon and anesthesiologist sharing the patient's airway, including:

- intracranial surgery
- oral surgery
- some types of dental surgery.

Basically, procedures involving the patient's head, neck, or shoulder girdle are good possibilities for field avoidance.

Caution: Don't automatically assume that field avoidance comes into play anytime you code a particular procedure, warns **Leslie Johnson, CPC, CSFAC**, manager of coding, compliance, and education for Somnia, Inc., in New Rochelle, N.Y. "I see many procedures performed by the same surgeon where some involve field avoidance and others don't," she says. "The surgeon uses a different technique for whatever reason that means field avoidance is not a factor."

Verify Patient Position

At other times, field avoidance applies when the surgeon needs to have the patient in a certain position for the procedure. The main consideration from your coding perspective is that the patient's position could cause the anesthesiologist to have difficulty accessing the patient's airway if problems arise during surgery and that could mean extra units for field avoidance.

Johnson shares some examples of several procedures that could involve field avoidance because of the patient's position:

- The patient might be in the prone position (lying face down) during a repair of his ankle tendon (27658, Repair, flexor tendon, leg; primary, without graft, each tendon). This crosses to anesthesia code 01470 (Anesthesia for procedures on nerves, muscles, tendons and fascia of lower leg, ankle and foot; not otherwise specified), which has 3 base units. The anesthesiologist can raise the procedure's base from 3 to 5 units for field avoidance because of the patient's position.
- The surgeon excises a sebaceous cyst on the back of the patient's thigh. The anesthesia code is 00400 (Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum; not otherwise specified) with 3 base units. Because the patient must be prone or lateral to allow the surgeon to reach that area, you can add 2 additional units and bill for 5 total base units.
- The patient is in the prone position during an elbow procedure so the surgeon can reach the right part of the elbow. Add 2 more units to code 01730 (Anesthesia for all closed procedures on humerus and elbow) if the anesthesiologist documents position or field avoidance.
- The patient is in the prone position during surgery to repair a calcaneal (heel) fracture. Both anesthesia codes for the procedure (01462,Anesthesia for all closed procedures on lower leg, ankle and foot; and 01480, Anesthesia for open procedures on bones of lower leg, ankle and foot; not otherwise specified) are 3 base units. You would raise either code to 5 units because of the patient's prone position.

Watch: As you study the surgical chart, check whether the surgeon changed the patient's position at some point during the procedure. While this is not a common occurrence, it also isn't completely unheard of especially for some cases involving multiple procedures during the same session (such as a mastectomy followed by reconstruction involving the latissimus dorsi).

"The surgeon may wish to have the patient's position changed at any given time during a surgical procedure," Johnson says. Because of that, a case that begins in the standard supine position might merit extra units for field avoidance before the procedure ends.

Documentation: Most anesthesia records have a place for the doctor to indicate the patient's position; if not, the table turning is a good indication of position. You must consider all of the available information (such as the patient's position and where on the body the procedure is performed) to determine whether coding for field avoidance is appropriate.

Tip: When you code for field avoidance, many coders recommend that you document it in Box 19 so the carrier knows why you're billing extra units.

Follow Payer Guidelines

CPT® does not include modifiers to indicate field avoidance, so you must add the extra units yourself (assuming the procedure's original value is less than 5). However, remember that some payers might not reimburse for field avoidance. For those that do, they often have specific guidelines you should follow. For example:

- Arkansas Medicaid wants you to append modifier 22 (Increased procedural services) when you bill for field avoidance.
- California's Medi-Cal has modifier ZA (Prone position or surgical field avoidance) to designate field avoidance.
- Some private payers request a paper claim for field avoidance. Some carriers want a modifier and no paperwork; others want no modifier but the term "field avoidance" or something similar somewhere on the claim.

This wide range of policies is why it's important to talk with individual payers. You're searching for information related to four key areas:

- whether the carrier in question has a policy regarding field avoidance
- what the policy is
- whether your contract with the carrier states that payment for "field avoidance" or "patient position" will be paid
- how to code correctly for field avoidance according to the carrier's guidelines.

Get It in Writing

Your final step in learning how to code for a particular carrier involves getting a copy of the policy in writing. "This avoids confusion and helps maintain compliance," Johnson says. "It also saves you time with appeals if you already have information in writing from the carrier."

"If the anesthesiologist (or CRNA) will document the degree of field avoidance, he stands to gain up to 2 extra base units for his fee," Johnson adds. "This might not seem like a lot, but after a while it adds up."

Bottom line example: Fees vary by region and by anesthesia group, but let's use $75 as the unit charge. The surgeon performs a procedure that crosses to 01470 (Anesthesia for procedures on nerves, muscles, tendons and fascia of lower leg, ankle and foot; not otherwise specified). Code 01810 is a 3-base-unit procedure, so you would normally charge $225 plus time (3 base units x $75 = $225). If the case involves field avoidance, bill $375 plus time (5 base units x $75 = $375)