



# Kansas City

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## Anesthesia Processing Guidelines

**Policy Number:** 10.01.511

**Last Review:** 5/2014

**Origination:** 10/1988

**Next Review:** 5/2015

### Policy

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The following guidelines are utilized in processing anesthesia claims:

1) **Anesthesia and Surgery by the Same Physician**

- a) If the same physician performs anesthesia and surgery, the anesthesia is considered inclusive with the surgery. No separate or additional benefit is available for the anesthesia, since the patient is not managed separately from an anesthesia standpoint.
- b) Anesthesia provided by a dentist is to be billed with the appropriate D-code.
- c) See also policy, Modifiers (Modifier -47)

2) **Continuous Epidural Analgesia for Labor and Delivery** 01960, 01961, 01967, 01968, 01969, 62319

- a) For a vaginal delivery, code 01967 has been added to the Procedure Tiers in Facets to allow one unit only. The code will be priced per the R&C schedule and automatically price one unit.
- b) For a vaginal delivery that turns into a Cesarean (C-section) using an epidural, use code 01967 which will price per the R&C Schedule and code 01968 (3 ASA units) plus the actual time units for the Cesarean.
- c) For a scheduled/planned Cesarean delivery using an epidural, use code 01961 (7 ASA units). This would allow the ASA value of 7 units plus the actual time units for the surgery.

***NOTE: 62319 is not to be used with the above coding since the anesthesia code includes the insertion of the epidural.***

**General anesthesia**

- d) For a vaginal delivery with general anesthesia (no epidural), use code 01960 (5 ASA units). This would allow the ASA value of 5 units plus the actual time units for the surgery.
- e) For a Cesarean delivery with general anesthesia (no epidural), use code 01961 (7 ASA units). This would allow the ASA value of 7 units plus the actual time units for the surgery.
- f) For a Cesarean hysterectomy following neuraxial labor analgesia/anesthesia, use code 01969 in addition to code 01967. This would allow the ASA value of 5 units for 01969 and 5 units for 01967 plus the actual time units for the surgery.

3) **Intravenous Sedation or Moderate Sedation** 99143, 99144, 99145, 99148, 99149, 99150

- a) A physician or trained health care professional administers medication that allows a decreased level of consciousness but does not put the patient completely asleep inducing a state called moderate (conscious) sedation. This allows the patient to breathe without assistance and respond to commands.
- b) Intravenous anesthesia or moderate sedation administered by a qualified medical person working under the direction of the physician for procedures appearing in Appendix G of the AMA's Current Procedure Terminology (CPT) book is considered a component of the procedure itself. No separate or additional reimbursement will be allowed. (CPT codes 99143, 99144 and 99145)

- c) Moderate sedation by a second physician (99148-99150) requires individual review and would be considered appropriate when ALL of the following are met:
  - i) Medically unstable patient or a patient for whom the sedation is necessary to allow safe completion of the procedure, AND
  - ii) Service provided in a facility, AND
  - iii) Service provided by a physician other than the health care professional performing the diagnostic or therapeutic service. Anesthesiologists should not use these codes.
- d) A separate benefit is not provided for supplies and medications related to intravenous sedation, as they are considered included in the reimbursement made for the procedure, or the facility fee paid to the provider.

4) **Intubation and Ventilation Services** 31500, 94002, 94003, 94004

- a) Endotracheal intubation performed by an anesthesiologist or CRNA in the course of a surgery is included in the time units reported for anesthesia.
- b) Endotracheal intubation performed independent of a surgery, by a physician or CRNA may be allowed as surgical procedure itself, not as an anesthesia service.
- c) Initiation of mechanical ventilation in the course of a surgery is included in the time units reported for anesthesia.
- d) Initiation of mechanical ventilation after endotracheal intubation (code 31500) performed independent of a surgery (e.g., in the intensive care setting) may be reimbursed separately.
- e) Ventilation management services will be reimbursed only one time per day.

5) **Local Anesthesia**

- a) Local anesthesia includes the direct infiltration of the incision, wound, or lesion, a digital block, or topical anesthesia.
- b) Local anesthesia is considered to be an integral part of the surgical procedure and no separate or additional reimbursement will be allowed.

6) **Monitored Anesthesia Care (MAC)**

- a) Like general anesthesia, MAC uses sedatives and other agents, but the dosage is low enough that patients remain responsive and breathe without assistance. MAC is often used to supplement local and regional anesthesia, particularly during simple procedures and minor surgery. During MAC, the patient is sedated and amnesic but always remains responsive when stimulated to do so. The patient is in a light sleep and may or may not wake up from time to time during the procedure even if he does not remember doing so. The patient breathes on his/her own and ventilation is not assisted as in general anesthesia. The patient is usually awake at the end of the procedure and can readily be discharged from the recovery room.
- b) The anesthesiologist or CRNA administering MAC must be continuously present to monitor the patient and provide anesthesia care. The MAC service must be reasonable and medically necessary under the given circumstances.
- c) Monitored anesthesia care includes all aspects of anesthesia care – a preprocedure visit, intraprocedure care and postprocedure anesthesia management. The anesthesiologist provides or medically directs a number of specific services, including but not limited to:
  - i) Diagnosis and treatment of clinical problems that occur during the procedure
  - ii) Support of vital functions
  - iii) Administration of sedatives, analgesics, hypnotics, anesthetic agents or other medications as necessary for patient safety
  - iv) Psychological support and physical comfort
  - v) Provision of other medical services as needed to complete the procedure safely.
- d) The provider of MAC must be prepared and qualified to convert to general anesthesia when necessary. If the patient loses consciousness and the ability to respond purposefully, the anesthesia care is a general anesthetic, irrespective of whether airway instrumentation is required.
- e) MAC is subject to the same level of reimbursement as general or regional anesthesia and is reported using the appropriate anesthesia code and modifier (QS).

- 7) **Patient Controlled Analgesia (PCA)** 01996, 36557, 36558, 36560, 36561, 36563, 36565, 36566, 36570, 36571, 36575, 36576, 36578, 36581, 36582, 36583, 36584, 36585, 36589, 36590, 62318, 62319, 62350, 62351, 62360, 62361, 62362
- a) The most common routes for Patient Controlled Analgesia (PCA) are:
    - i) Intravenous – (into a vein) the pump and tubing are connected to a needle or soft catheter that has been placed in a vein.
    - ii) Subcutaneous – (under the skin) the pump and tubing are connected to a small thin needle that is placed under the skin.
    - iii) Epidural – into the area surrounding the dural membrane, which contains cerebral spinal fluid and spinal nerves or
    - iv) Intrathecal – (through the dural membrane and into the spinal fluid) the pump and tubing are connected to a flexible catheter that causes drug to come in contact with spinal nerves.
  - b) Patient controlled analgesia refers to a method of giving pain medication that can be controlled by the patient, within the physician's prescribed parameters. These parameters are programmed into a computerized or mechanical pump and may deliver either boluses (a “shot”) of the pain medication when the patient pushes a button or a basal rate (continuous dose) or both.
  - c) With the lower doses generally needed to obtain pain relief, side effects such as nausea, sedation and respiratory depression can be minimized. This type of pain control is used extensively for postoperative pain. It is also used for management of pain due to cancer and for chronic intractable pain of non-cancerous origin.
  - d) PCA may be utilized in the home under the care of a licensed home health agency or in the hospital setting.
  - e) Intravenous or subcutaneous PCA:
    - i) When PCA is initiated by an anesthesiologist before the patient leaves the operating room or in the recovery room immediately after surgery, the set-up time may be incorporated into the total number of anesthesia time units reported.
    - ii) Any intravenous or subcutaneous PCA follow-up services performed after the surgical anesthesia care has ended are considered routine postoperative pain management, regardless of who performs them. When performed by the physician who administered anesthesia, or by a member of his group or association, the postoperative pain management is considered part of the global anesthesia allowance. As such, if billed separately, the pain management is not covered.
    - iii) Intravenous or subcutaneous PCA ordered by the surgeon, or other attending physician and administered for pain management is considered an integral part of a physician's medical care. It is not eligible for benefit as a separate and distinct service.
    - iv) If an anesthesia consultation is required for pain management, whether or not it results in initiation of PCA (intravenous or subcutaneous), the anesthesiologist should submit a claim under the appropriate CPT Evaluation and Management code.
    - v) 01999 may not be used to bill for PCA Management
  - f) Epidural (or subarachnoid, or intrathecal) PCA:
    - (b) For the insertion of an epidural catheter to be separately reimbursable with the -59 modifier, it must be performed outside of the general anesthesia time. If the epidural catheter is placed in the operating room when the anesthesiologist is tracking time for the general anesthetic procedure, it would not be separately reimbursable. If, however, the epidural placement is done pre-op or post-op for pain management, then it would be appropriate for the provider to bill with the -59 modifier and get reimbursed separately. 62319 will not be reimbursed in addition to continuous epidural analgesia for labor and delivery 01960, 01961, 01967, 01968 (see Item 3, above).
    - ii) Daily Management of epidural drug administration (code 01996) is also eligible for separate payment after the day on which the catheter is inserted. Daily Management reported on the same day as the catheter insertion is considered inclusive with the insertion.
    - iii) Daily pain management services beyond three days may be subject to medical review for medical necessity.

- iv) Payment can also be made for the insertion of an epidural catheter (codes 62318 and 62319, as appropriate) for the treatment of a nonsurgical condition. Daily Management of epidural drug administration (code 01996) is also eligible for separate payment after the day on which the catheter is inserted. Daily Management reported on the same day as the catheter insertion is considered inclusive with the insertion.

## 8) **Pre-Anesthetic Evaluation**

- a) The pre-anesthetic evaluation should include the following components at a minimum:
  - i) An evaluation of chief complaints
  - ii) Past medical history
  - iii) Review of individual sensitivities to drugs and biologicals
  - iv) Assessment of the patient as a whole,
- b) The pre-anesthesia evaluation is considered an integral part of the anesthesia service and separate benefits are not provided, with the following exception:
  - i) Benefit may be provided at the E & M (evaluation and management) level of care rendered (under CPT consultation codes) by an anesthesiologist only if the anesthesia is not subsequently administered during the same hospital stay.

## 9) **Regional Nerve Blocks** 64400, 64402, 64405, 64408, 64410, 64412, 64413, 64415, 64416, 64417, 64418, 64420, 64421, 64425, 64430, 64435, 64445, 64446, 64447, 64448, 64449, 64450

- a) In a regional (or field) block, medication is injected around a large nerve or nerves. These nerves give sensation to the site of the procedure. Regional blocks are usually done in an operating room. Unlike local numbing, the medication is injected far away from the procedure site. Although regional blocks cause a larger area of the body to be numb than local anesthesia, the medication is the same.
- b) Nerve blocks may be used for:
  - i) Surgery – to provide anesthesia for orthopedic, obstetric, and vascular surgical procedures.
  - ii) Therapeutic – to treat chronic pain in certain areas of the body. The effect is usually temporary, although the length of effect may vary greatly, from hours to months.
  - iii) Diagnostic – to diagnose which neural pathway is causing the chronic pain.
- c) **Blocks done by an anesthesiologist for anesthetic purposes:**
  - i) Anesthetic blocks performed by an anesthesiologist or CRNA for an operative procedure should be processed as general anesthesia, based on the anesthesia value for the surgical procedure and duration of the anesthesia period.
- d) **Blocks done for diagnostic or therapeutic purposes:**
  - i) If the block is done for post-op analgesia (pain management) and is not the primary anesthetic for the surgical procedure, then it would be appropriate for the provider to bill with the -59 modifier and get reimbursed separately. Whether the block procedure occurs preoperatively, postoperatively, or during the procedure is immaterial.
  - ii) When there is no separate operative procedure performed and the anesthesiologist performs a block as treatment for intractable pain, the claim should be processed under the appropriate CPT code and reimbursed as surgery.

## 10) **Stand-by Anesthesia** 99360

- a) Standby service describes a physician who is available in the immediate area to perform needed service. There is no direct patient contact included in the standby service.
- b) Stand-by anesthesia services are not eligible for coverage even when required by the facility in which the patient is to have surgery. When there is no direct patient care by the anesthesiologist or CRNA (e.g., anesthesia availability for PTCA, delivery, etc.) no benefit is provided.

## **Description of Procedure or Service**

When multiple surgical procedures are performed during a single anesthetic administration, the anesthesia code representing the most complex procedure is reported. The time reported is the combined total for all procedures.

The administration of anesthesia services is appropriate by an anesthesiologist or Certified Nurse Anesthetist (CRNA) under the responsible supervision of an anesthesiologist. These services include the usual preoperative and postoperative visits, the anesthesia care during the procedure, the administration of fluids and/or blood and the usual monitoring services (eg, ECG, temperature, blood pressure, oximetry, capnography and mass spectrometry).

The period of time on which anesthesia time units are based begins when the anesthesiologist or CRNA is first in attendance with the patient for the purpose of induction of anesthesia, and ends when the patient leaves the operating room, delivery room, or treatment room (in the case of Monitored Anesthesia Care or MAC). Time spent in the recovery room is included in the anesthesia base units and no additional units of time are provided.

The following components are considered an integral part of the anesthesia service and additional benefits are not provided:

- Pre-anesthesia evaluation;
- Postoperative visits;
- Anesthetic or analgesic administration;
- All necessary monitoring

### **Billing Coding/Physician Documentation Information**

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<b>01960</b>	Anesthesia for vaginal delivery only
<b>01961</b>	Anesthesia for cesarean delivery only
<b>01967</b>	Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)
<b>01968</b>	Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed)
<b>01969</b>	Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed)
<b>01996</b>	Daily hospital management of epidural or subarachnoid continuous drug administration
<b>31500</b>	Intubation, endotracheal, emergency procedure
<b>36557</b>	Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; younger than 5 years of age
<b>36558</b>	Insertion of tunneled centrally inserted central venous catheter, without subcutaneous port or pump; age 5 years or older
<b>36560</b>	Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; younger than 5 years of age
<b>36561</b>	Insertion of tunneled centrally inserted central venous access device, with subcutaneous port; age 5 years or older
<b>36563</b>	Insertion of tunneled centrally inserted central venous access device with subcutaneous pump
<b>36565</b>	Insertion of tunneled centrally inserted central venous access device, requiring 2 catheters via 2 separate venous access sites; without subcutaneous port or pump (eg, Tesio type catheter)
<b>36566</b>	Insertion of tunneled centrally inserted central venous access device, requiring 2 catheters via 2 separate venous access sites; with subcutaneous port(s)
<b>36570</b>	Insertion of peripherally inserted central venous access device, with subcutaneous port; younger than 5 years of age
<b>36571</b>	Insertion of peripherally inserted central venous access device, with subcutaneous port; age 5 years or older
<b>36575</b>	Repair of tunneled or non-tunneled central venous access catheter, without subcutaneous port or pump, central or peripheral insertion site
<b>36576</b>	Repair of central venous access device, with subcutaneous port or pump, central or peripheral insertion site
<b>36578</b>	Replacement, catheter only, of central venous access device, with subcutaneous port or

- pump, central or peripheral insertion site
- 36581** Replacement, complete, of a tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access
- 36582** Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous port, through same venous access
- 36583** Replacement, complete, of a tunneled centrally inserted central venous access device, with subcutaneous pump, through same venous access
- 36584** Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access
- 36585** Replacement, complete, of a peripherally inserted central venous access device, with subcutaneous port, through same venous access
- 36589** Removal of tunneled central venous catheter, without subcutaneous port or pump
- 36590** Removal of tunneled central venous access device, with subcutaneous port or pump, central or peripheral insertion
- 62318** Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic
- 62319** Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)
- 62350** Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy
- 62351** Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; with laminectomy
- 62360** Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir
- 62361** Implantation or replacement of device for intrathecal or epidural drug infusion; nonprogrammable pump
- 62362** Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming
- 64400** Injection, anesthetic agent; trigeminal nerve, any division or branch
- 64402** Injection, anesthetic agent; facial nerve
- 64405** Injection, anesthetic agent; greater occipital nerve
- 64408** Injection, anesthetic agent; vagus nerve
- 64410** Injection, anesthetic agent; phrenic nerve
- 64412** Injection, anesthetic agent; spinal accessory nerve
- 64413** Injection, anesthetic agent; cervical plexus
- 64415** Injection, anesthetic agent; brachial plexus, single
- 64416** Injection, anesthetic agent; brachial plexus, continuous infusion by catheter (including catheter placement)
- 64417** Injection, anesthetic agent; axillary nerve
- 64418** Injection, anesthetic agent; suprascapular nerve
- 64420** Injection, anesthetic agent; intercostal nerve, single
- 64421** Injection, anesthetic agent; intercostal nerves, multiple, regional block
- 64425** Injection, anesthetic agent; ilioinguinal, iliohypogastric nerves
- 64430** Injection, anesthetic agent; pudendal nerve
- 64435** Injection, anesthetic agent; paracervical (uterine) nerve
- 64445** Injection, anesthetic agent; sciatic nerve, single
- 64446** Injection, anesthetic agent; sciatic nerve, continuous infusion by catheter (including catheter placement)
- 64447** Injection, anesthetic agent; femoral nerve, single

- 64448** Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement)
- 64449** Injection, anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)
- 64450** Injection, anesthetic agent; other peripheral nerve or branch
- 94002** Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day
- 94003** Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, each subsequent day
- 94004** Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; nursing facility, per day
- 99143** Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; younger than 5 years of age, first 30 minutes intra-service time
- 99144** Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; age 5 years or older, first 30 minutes intra-service time
- 99145** Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes intra-service time (List separately in addition to code for primary service)
- 99148** Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician or other qualified health care professional other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; younger than 5 years of age, first 30 minutes intra-service time
- 99149** Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician or other qualified health care professional other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; age 5 years or older, first 30 minutes intra-service time
- 99150** Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician or other qualified health care professional other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intra-service time (List separately in addition to code for primary service)
- 99360** Standby service, requiring prolonged attendance, each 30 minutes (eg, operative standby, standby for frozen section, for cesarean/high risk delivery, for monitoring EEG)

### **Additional Policy Key Words**

N/A

### **Policy Implementation/Update Information**

- 10/1/88 New policy.
- 6/1/00 No policy statement changes.
- 6/1/01 Policy revised to address each heading as a separate policy.
- 4/1/02 No policy statement changes.
- 4/1/03 No policy statement changes.
- 1/1/04 Policy revised to include specific processing instructions for *Continuous Epidural*

	<i>Analgesia for Labor and Delivery</i> for dates of service before and after 10/1/2003.
4/1/04	No policy statement changes.
4/1/05	Policy revised to address each heading on the Anesthesia Processing Guidelines policy. <i>Acupuncture</i> and <i>Hypnosis</i> are removed from this policy and addressed under separate policies.
4/1/06	Policy revised to include guideline for code 01969 under the heading of <i>Continuous Epidural Analgesia for Labor and Delivery</i> . Policy revised under the heading of <i>Intravenous Sedation or Moderate Sedation</i> to include the statement that moderate sedation by a second physician (99148-99150) requires individual review.
4/1/07	No policy statement changes.
6/1/07	Policy clarification made to Item 7f (Epidural PCA)
5/1/08	Policy statement revised regarding post-op pain blocks administered before, during, or after surgery. If done for post-op pain management, it would be separately payable. Policy statement revised regarding anesthesia and surgery by the same physician. Anesthesia provided by a dentist is to be billed with the appropriate D-code.
5/1/09	No policy statement changes.
9/1/09	Policy statement revised regarding moderate sedation by the surgeon. This may be considered separately payable per CPT guidelines.
5/1/10	No policy statement changes.
5/1/11	Policy statement revised regarding continuous epidural analgesia for labor and delivery; instructions for dates of service prior to October 1, 2004 removed from the policy.
5/1/12	No policy statement changes.
5/1/13	No policy statement changes.
5/1/14	No policy statement changes. Coding updated.

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State and Federal mandates and health plan contract language, including specific provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The medical policies contained herein are for informational purposes. The medical policies do not constitute medical advice or medical care. Treating health care providers are independent contractors and are neither employees nor agents Blue KC and are solely responsible for diagnosis, treatment and medical advice. No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, photocopying, or otherwise, without permission from Blue KC.