Coding and Payment Guide for Anesthesia Services

An essential coding, billing, and reimbursement resource for anesthesiology and pain management

2013
Coding and Payment Guide for Anesthesia Services

Introduction

Medicare Part B covered services. Medicare Part A coverage includes inpatient hospital, skilled nursing facilities (SNF), hospice, and home health. Medicare Part B coverage provides payment for medical supplies, physician, and outpatient services.

Not all services rendered by a facility are inpatient services. Providers working in facilities routinely render services on an outpatient basis. Outpatient services are provided in settings that include rehabilitation centers, certified outpatient rehabilitation facilities, SNFs, and hospitals. Outpatient and partial hospitalization facility claims might be submitted on either a CMS-1500 or UB-04, depending on the payer.

For professional component billing, most claims are filed using CPT codes to identify the service provided, and HCPCS Level II codes to report supplies on the CMS-1500 paper claim or the 837P electronic format.

Contents and Format of This Guide

The first three chapters following this introduction provide information regarding the reimbursement process, documentation, and claim completion, respectively. The fifth chapter, “Procedure Codes,” contains a numeric listing of procedure codes. Each page identifies the information associated with that procedure including an explanation of the service, coding tips, associated diagnoses, related terms, CMS internet-only manual references that identify any official references found in the online CMS Manual System. The full excerpt from the online CMS Manual System pertaining to the reference is provided in the Medicare official regulatory chapter. The procedure code pages also have a list of codes from the official Centers for Medicare and Medicaid Services National Correct Coding Policy Manual for Part B Medicare Contractors that are considered to be an integral part of the comprehensive or mutually exclusive and should not be reported separately. Finally, all relative value schedule references. The Terms to Know section may be used ensure appropriate code assignment.

Medicare Official Regulatory Information

The full excerpts from the online CMS Manual System pertaining to anesthesia are provided in this section. Since these excerpts often do not identify the guideline with corresponding CPT or HCPCS Level II codes our experts have crosswalked the appropriate reference, wherever possible, to the applicable procedure or supply code. This crosswalk reference is listed under each applicable CPT or HCPCS code in the definitions, guidelines, and index section. The excerpts are listed in this section in numeric order.

Index and Appendixes

The final section consists of a comprehensive index that provides a list of pages on which each term is discussed, and a glossary of coding, billing, and clinical terms applicable to your specialty. Appendix A contains a list of base units for CPT codes.

How to Use This Guide

The first three chapters: “The Reimbursement Process,” “Documentation—An Overview,” and “Claims Processing” may be read in their entirety and/or used as references. When using this Coding and Payment Guide for code assignment, follow these important steps to improve accuracy and experience fewer overlooked diagnoses and services:

- **Step 1.** Carefully read the medical record documentation that describes the patient’s diagnosis and the service provided. Remember, more than one diagnosis or service may be documented.
- **Step 2.** Locate the main term for the procedure or service documented in the CPT index. This will identify the procedure code that may be used to report this service.
- **Step 3.** Locate the procedure code in the chapter titled “Procedure Codes.” Read the explanation and determine if that is the procedure performed and supported by the medical record documentation. The Terms to Know section may be used ensure appropriate code assignment.
- **Step 4.** At this time you can review the additional information pertinent to the specific code found in the coding tips, IOM reference, and CCI sections or the Medicare physician fee schedule references.
- **Step 5.** Peruse the list of ICD-9-CM codes to determine if the condition documented in the medical record is listed and the code identified.
- **Step 6.** Determine if any Medicare regulatory information is associated with this code and if so, an excerpt of this information may be found in the appendix titled, “Medicare Official Regulatory Information.”
- **Step 7.** Finally, review the HCPCS Level II section to determine if there are applicable HCPCS Level II codes that may be reported. This section also includes HCPCS Level II modifiers as well as coding tips.
Procedure Codes

00174-00176

00174  Anesthesia for introral procedures, including biopsy; excision of retropharyngeal tumor

00176  radical surgery

Coding Tips

The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Surgical to Anesthesia Code Crosswalk

41135, 41140, 41145, 41153, 41155, 42842, 42844, 42845, 42890, 42892, 42894

ICD-9-CM Diagnoses

141.0  Malignant neoplasm of base of tongue
141.1  Malignant neoplasm of dorsal surface of tongue
141.2  Malignant neoplasm of tip and lateral border of tongue
141.3  Malignant neoplasm of ventral surface of tongue
141.4  Malignant neoplasm of anterior two-thirds of tongue, part unspecified
141.5  Malignant neoplasm of junctional zone of tongue
141.6  Malignant neoplasm of lingual tonsil
141.8  Malignant neoplasm of other sites of tongue
142.2  Malignant neoplasm of sublingual gland
143.1  Malignant neoplasm of lower gum
144.0  Malignant neoplasm of anterior portion of floor of mouth
144.1  Malignant neoplasm of lateral portion of floor of mouth
144.8  Malignant neoplasm of other sites of floor of mouth
145.6  Malignant neoplasm of retromolar area
145.8  Malignant neoplasm of other specified parts of mouth
145.9  Malignant neoplasm of mouth, unspecified site
146.0  Malignant neoplasm of tonsil
146.1  Malignant neoplasm of tonsillar fossa
146.2  Malignant neoplasm of tonsillar pillars (anterior) (posterior)
146.3  Malignant neoplasm of vallecula
146.4  Malignant neoplasm of anterior aspect of epiglottis
146.5  Malignant neoplasm of junctional region of oropharynx
146.6  Malignant neoplasm of lateral wall of oropharynx
146.7  Malignant neoplasm of posterior wall of oropharynx
146.8  Malignant neoplasm of other specified sites of oropharynx
147.1  Malignant neoplasm of posterior wall of nasopharynx
147.2  Malignant neoplasm of lateral wall of nasopharynx
147.3  Malignant neoplasm of anterior wall of nasopharynx
148.1  Malignant neoplasm of pyriform sinus
149.0  Malignant neoplasm of pharynx, unspecified
170.1  Malignant neoplasm of mandible
171.0  Malignant neoplasm of connective and other soft tissue of head, face, and neck
195.0  Malignant neoplasm of head, face, and neck
196.0  Secondary and unspecified malignant neoplasm of lymph nodes of head, face, and neck
210.5  Benign neoplasm of tonsil
210.6  Benign neoplasm of other parts of oropharynx
210.7  Benign neoplasm of nasopharynx
210.8  Benign neoplasm of hypopharynx
230.0  Carcinoma in situ of lip, oral cavity, and pharynx
235.0  Neoplasm of uncertain behavior of major salivary glands
235.1  Neoplasm of uncertain behavior of lip, oral cavity, and pharynx
238.0  Neoplasm of uncertain behavior of bone and articular cartilage
238.8  Neoplasm of uncertain behavior of other specified sites
239.0  Neoplasm of unspecified nature of digestive system
472.1  Chronic pharyngitis — (Use additional code to identify infectious organism)
478.21  Cellulitis of pharynx or nasopharynx — (Use additional code to identify infectious organism)

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References

100-4,4,10.4; 100-4,4,10.5; 100-4,4,10.10; 100-4,4,250.3.2; 100-4,4,250.3.3.1

CCI Version 17.3


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

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