Coding for Anesthesia Services

INTRODUCTION

It is apparent that confusion exists regarding the proper coding of anesthesia services performed by the OMS. Definitions for levels of sedation and anesthesia may be found in the AAOMS Parameters of Care, the American Dental Association's (ADA) Current Dental Terminology (CDT) Manual and the AMA Current Procedural Terminology (CPT). In addition, levels of anesthesia and sedation may be defined in individual state board regulations.

The codes utilized in this paper are from CPT 2013 and CDT 2013.

This paper will provide general guidelines only. Because significant variations may exist between regions, states and individual carriers, there is no single rule that uniformly governs this unique service. Ultimately, how anesthesia services provided by the surgeon are coded and billed depends on each individual carrier.

Familiarity and compliance with the other AAOMS coding papers, particularly those related to ICD-9-CM diagnostic coding and procedural coding guidelines utilizing CPT, HCPCS and CDT are necessary to utilize these codes properly.

Participation in AAOMS Coding courses will provide valuable information to facilitate the correct use of the codes.

REQUIRED CODING MATERIALS

Before attempting to code any claims for services, it is necessary to have a current copy of the American Dental Association's CDT, the American Medical Association's CPT, and the two-volume set of ICD-9-CM. Volumes 1 and 2 of the ICD-9-CM cover diagnostic coding which is mandatory in filing claims to medical third party payers and Medicare. Volume 1 represents a tabular listing of conditions, diseases, and symptoms; while volume 2 is the alphabetical listing. Volume 3 of the ICD-9-CM is only for hospitals, and is not necessary for the OMS office.

CDT 2013 went into effect January 1, 2013 and is the most recent edition. It supersedes all previous CDT manuals and contains numerous updates and modifications. Previously, CDT was a five-digit system, however, in the CDT-3 version the initial zero was changed to a "D." With the reformation of the ADA's Coding Maintenance Committee, CDT will now be updated annually.

CPT, CDT and ICD-9-CM are revised annually. The new edition of CPT becomes available in mid-November and effective January 1 of the following year. Bi-annual code changes to ICD-9-CM implemented by the government used to take effect October 1 and April 1 and were valid through the following September 30. However, with the implementation date for ICD-10-CM approaching, the government has placed a freeze on ICD-9-CM code changes. Thus, reporting a current procedure or diagnosis using a previous year's edition may be inaccurate and adversely affect reimbursement or lead to unnecessary delays in claims processing.

CODING FOR ANESTHESIA SERVICES USING CPT CODES

Under both medical (CPT) and dental (CDT) coding, the use of local anesthesia is considered an inherent component of any surgical procedure, and is not billable separately.

Moderate (Conscious) Sedation

Six CPT codes (99143, 99144, 99145, 99148, 99149 and 99150) were introduced in CPT 2006 for reporting "moderate (conscious) sedation" and two codes were eliminated (99141 and 99142). The ASA and CPT define Moderate Sedation /Analgesia as a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. These codes are:

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 age 5 years or older, first 30 minutes intra-service time

+ 99145 each additional 15 minutes intra-service time (List separately in addition to code for primary service); note that this is an add-on code and must be used in conjunction with 99143, 99144

99148 Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician or qualified health care professional other than the health care professional performing the diagnostic or therapeutic service that sedation supports; younger than 5 years of age, first 30 minutes intra-service time

99149 age 5 years or older, first 30 minutes intra-service time

+ 99150 each additional 15 minutes intra-service time (List separately in addition to code for primary service); note that this is an add-on code and must be used in conjunction with 99148, 99149

In CPT 2013 there are many codes that have a "bulls-eye" designation 8 in front of the code. These codes have moderate (conscious) sedation by the surgeon included in the RVUs for that code. None of these codes are currently utilized by the OMS.

Deep Sedation / General Anesthesia

To report general anesthesia/deep sedation provided by the surgeon performing the surgical procedure, it is necessary to add modifier "-47" to the surgical procedure code. Modifier "-47" is not used as a modifier for the CPT Anesthesia Codes (00100 - 00352 for head and neck procedures) as these reflect anesthesia services provided by an individual other than the operating surgeon. (Note: The five digit modifier format was eliminated from CPT beginning in 2003 making the previous 09947 obsolete). For example, closed reduction of a mandibular fracture performed in the office under deep sedation / general anesthesia would be reported as: 21451 for the procedure, with 21451-47 as a separate line item for the anesthesia.

Some insurance companies will permit surgeons to report their anesthesia services by utilizing codes from the Anesthesia chapter of the CPT Manual. Such anesthesia services are reported by the use of the anesthesia five digit procedure code plus the addition of a physical status modifier. CPT codes 00100 through 00352 are the anesthesia codes for the head and neck region. Unless advised otherwise by a carrier, these codes are intended to be reported by a provider administering anesthesia for the operating surgeon, or overseeing a CRNA. In either case, these codes are not generally used to report operator administered anesthesia.

The surgeon may be able to bill for supply of the anesthetic agent, as well as possibly for IV antibiotics, analgesics and anti-inflammatory agents. The CPT supply code is 99070. Some insurance companies may prefer the appropriate HCPCS Level II code representing the drugs administered (J codes).

Anesthesia Relative Values

According to the American Society of Anesthesiologists (ASA) Relative Value Guide, a "Basic Value" is assigned to the anesthetic management of most surgical procedures. This "Basic Value" includes "all usual anesthesia services," except for the time actually spent in anesthesia care and any modifiers. "Usual anesthesia services" includes usual pre- and post-operative visits, administration of fluids and/or blood products incident to anesthesia care, and the interpretation of noninvasive monitoring (e.g., ECG, temperature, blood pressure, oximetry, capnography). When more than one surgical procedure is performed during a single anesthetic, the "Basic Value" would be that of the procedure which has the highest unit value.

In addition to the "Basic Value," additional modifiers are used to accurately code and bill for services. These modifiers are primarily the "Modifying Units" [see below] and "Time Units." Other modifiers exist, but have little or no relevance to practicing OMS's.

Physical Status Modifiers

Physical Status Modifiers should be appended to any CPT anesthesia chapter code. They are indicated with the initial

letter "P" followed by a single digit from 1-6 as listed below:

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 - Moribund patient, not expected to survive without the operation.

P6 - Declared brain-dead patient whose organs are being removed for donor purposes.

These six levels are consistent with the ASA classification of physical status and are added to the basic anesthesia code in the same fashion as any CPT modifier. (Example: 00190 - P2)

Qualifying Circumstances

Though technically not modifiers, these codes serve to describe anesthesia services under unusual or difficult circumstances. Such unusual circumstances and services may qualify for additional reimbursement when reported in addition to the anesthesia code. These codes are not reported alone, but in addition to the qualifying anesthesia procedure or service. More than one CPT code may be used.

+99100 Anesthesia for patient of extreme age, under one year or over 70.

+99116 Anesthesia complicated by utilization of total body hypothermia.

+99135 Anesthesia complicated by utilization of controlled hypotension.

+99140 Anesthesia complicated by emergency conditions (specify).

[Emergency is defined as existing when delay in treatment would lead to a significant increase in the threat to life or body part.]

Reporting Time

The other factor to consider when billing for anesthesia services is time. Anesthesia time begins when the anesthesia provider begins to prepare the patient for induction of anesthesia (typically when the intravenous access is established) and ends when he/she is no longer in personal attendance (i.e., when the patient is safely placed under postoperative supervision). This is expressed as "Time Units." The basic "Time Unit" is generally considered to be 15 minutes. However, carriers may vary in how they define "Time Unit." For example, 10 minutes could be considered the basic unit for some carriers. Be sure to verify with specific carriers how they define such time units, and how they would like time reported. The HIPAA Electronic Transaction Standard 5010 no longer accepts units, and requires the reporting of total anesthesia time. The total time is coded on the claim form under the column for "Units." The official instructions for completing the CMS 1500 are maintained by the National Uniform Claim Committee (NUCC). The most recent instructions provide guidance on reporting time above the date field in box 24 of the claim form. For a visual example, visit nucc.org and download the most current instructions.

WHAT ABOUT MEDICARE?

Under Medicare, deep sedation/general anesthesia is covered only for Medicare-covered procedures, and only if administered by another doctor or nurse anesthetist **under the supervision of another doctor**. Medicare presently bundles the payment for deep sedation/general anesthesia administered by or under the supervision of the operating surgeon.

Thus, general anesthesia/deep sedation by surgeon is **non-covered and non-billable** for Medicare covered services. If, however, anesthesia is billed by a separate individual for a Medicare-covered service, time should be reported in accordance with policies of your local Medicare Administrative Contractor and the current instructions set forth by the National Uniform Claim Committee available at http://www.nucc.org.

Moderate sedation by the surgeon, on the other hand, is carrier priced. This allows individual Medicare Part B carriers discretion regarding approval and payment rates.

DENTAL CODING FOR ANESTHESIA

Under both medical (CPT) and dental (CDT) coding, the use of local anesthesia is considered an inherent component of any surgical procedure, and is not billable separately.

Significant differences exist between anesthesia billing under CPT and CDT. Notable among these are the absence of modifiers and the "Time Unit" concept. CDT does not distinguish between operator administered anesthesia and that provided by another practitioner. The concepts of facility, supplies and materials are also inherently different in dental and medical billing. It is important to keep these differences in mind when coding.

When submitting anesthesia charges to a dental insurance carrier, the following CDT 2013 codes should be used:

D9220 deep sedation/general anesthesia - first 30 minutes

D9221 deep sedation/general anesthesia - each additional 15 minutes

D9230 analgesia, anxiolysis, inhalation of nitrous oxide

D9241 intravenous conscious sedation/analgesia – first 30 minutes

D9242 intravenous conscious sedation/analgesia – each additional 15 minutes

D9248 non-intravenous conscious sedation

DEFINING START AND STOP TIME

As noted, anesthesia start time commences when the anesthesia provider initiates the appropriate anesthesia protocol and remains in **continuous attendance** of the patient. Anesthesia time ends when the anesthesia provider can safely leave the patient under postoperative supervision. Thus, anesthesia services and time are considered completed when the patient may be safely left under the observation of a trained anesthesia assistant, and the doctor may safely leave the room to attend to other duties.

Additional CDT anesthesia codes exist, **but do not apply to anesthesia utilized in conjunction with a procedure.** ***These codes are:***

D9210 local anesthesia not in conjunction with operative or surgical procedures

D9211 regional block anesthesia

D9212 trigeminal division block anesthesia

D9215 local anesthesia in conjunction with operative or surgical procedures

Coding Paper

USING DENTAL CODES ON MEDICAL CLAIMS

In general, CPT codes are not used on ADA forms and CDT codes are not used on CMS 1500 (Medical) forms. However, some medical carriers may direct that you use CDT codes on a CMS 1500 form for "dental" procedures which do not have an applicable CPT code (e.g. third molars). In those situations, they may also request use of CDT anesthesia codes.

The presence of an anesthesia code, or any procedure code, does not guarantee payment for these services. It is crucial for the OMS practitioner and his/her staff to understand the intricacies of reimbursement for anesthesia services by each carrier, managed care organization and Medicare.

Note: This paper should not be used as the sole reference in coding. Both diagnosis and treatment codes change frequently, and insurance carriers may differ in their interpretations of the codes.

Coding and billing decisions are personal choices to be made by individual oral and maxillofacial surgeons exercising their own professional judgment in each situation. The information provided to you in this paper is intended for educational purposes only. In no event shall AAOMS be liable for any decision made or action taken or not taken by you or anyone else in reliance on the information contained in this article. For practice, financial, accounting, legal or other professional advice, you need to consult your own professional advisers.

This is one in a series of AAOMS papers designed to provide information on coding claims for oral and maxillofacial surgery (OMS). This paper discusses coding for anesthesia. This paper is to aid the oral and maxillofacial surgeon with proper diagnosis (ICD-9-CM) and treatment (CPT/CDT) coding for anesthesia. When indicated, you will be referred to the appropriate area of the coding books where the principles of coding illustrated in this paper may be applied.

Proper coding provides a uniform language to describe medical, surgical, and dental services. Diagnostic and procedure codes are continually updated or revised. The AAOMS Committee on Health Care and Advocacy has developed these coding guidelines in order to assist the membership to use the coding systems effectively and efficiently.

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