American Society of Anesthesiologists®

Timely Topics
PAYMENT AND PRACTICE MANAGEMENT

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ASA Statements/Expert Consensus Documents Relevant to Coding and Billing

We all know that any advice we follow on coding and billing should come from an informed source. As such, many look for an ASA position or stance for information on how to report specific scenarios. In this Timely Topic, we provide an overview of some ASA positions and statements that provide information on coding/billing matters. These statements and expert consensus documents were developed by ASA committees and represent the opinions and judgments of the committee members. The decision on what CPT® or ICD-10-CM codes to submit on a claim for services rests with the physician or other qualified healthcare professional who provided the care.

Position on Monitored Anesthesia Care

This statement offers an overview of some of the specific services included in Monitored Anesthesia Care (MAC). In its current version (as last amended October 2013) it also notes that, *"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."* This is an important change from an earlier version that stated, *"Monitored anesthesia care refers to those clinical situations in which the patient remains able to protect the airway for the majority of the procedure."*

Distinguishing Monitored Anesthesia Care ("MAC") from Moderate Sedation/Analgesia (Conscious Sedation)

The CPT® code set has included codes to describe conscious sedation since 1998. The first iteration included two codes that differentiated the route of administration (intravenous, intramuscular or inhalation vs. oral, rectal, and/or intranasal). The codes were reported by the practitioner who was performing the underlying procedure. Anesthesia codes were to be used to report sedation by a second separate provider.

CPT 2006 introduced new codes for moderate (conscious sedation). These codes were time-based and did not address route of administration. Instead, they were granular in terms of patient age and whether the sedation was being done by the same provider performing the diagnostic/therapeutic procedure or by a separate provider. The new codes resulted in the need for information on how to distinguish between MAC and moderate sedation. (NOTE: Moderate sedation coding was further revised in CPT 2017)

The ASA's statement Distinguishing Monitored Anesthesia Care ("MAC") from Moderate Sedation/Analgesia (Conscious Sedation) clarifies that MAC is "…*clearly distinct from Moderate Sedation due to the expectations and qualifications of the provider who must be able to utilize all anesthesia resources to support life and to provide patient comfort and safety during a diagnostic or therapeutic procedure."*

Statement on Intravascular Catheterization Procedures
This important statement provides clarification and justification that placement of invasive monitoring devices (eg, arterial lines, central venous lines and pulmonary artery catheters) is separately reportable from an anesthesia service. Additionally, this statement includes examples of how these lines are used and addresses some common bundling issues.

Statement on Transesophageal Echocardiography
In addition to providing a listing of the CPT codes that describe transesophageal echocardiography (TEE), this statement offers examples of why the services are performed and some of the risks and complexities associated with TEE. As with the Statement on Intravascular Catheterization Procedures, this statement also addresses bundling issues to help facilitate proper reporting. Additionally, it explains why TEE may be separately reportable from anesthesia care. (NOTE: The National Correct Coding Initiative (NCCI) allows override of edits pairing codes 93312-93317 with anesthesia care when the TEE is done for diagnostic purposes.)

Reporting Postoperative Pain Procedures in Conjunction with Anesthesia
It is very important to understand the circumstances under which a pain procedure may be reported along with an anesthesia service. This statement explains those circumstances, which include:

- The anesthesia for the surgical procedure was not dependent upon the efficacy of the regional anesthetic technique.
- The time spent on pre- or postoperative placement of the block is separated and not included in reported anesthesia time.
- Time for a post surgical block that occurs after induction and prior to emergence does not need to be deducted from reported anesthesia time.

This statement also recommends that documentation discuss how:

- The surgeon requested that the anesthesia team participate in the provision of postoperative analgesia,
- The patient was involved in the process of defining the best plan for such analgesia,
- The patient received additional information about the risks and benefits of such therapy *separate from the information regarding the anesthetic itself*, and consented to the post surgical pain procedure.

Statement on Anesthetic Care During Interventional Pain Procedures for Adults
In some, but not all, instances, adult patients undergoing interventional pain procedures may not require anesthesia care. As discussed within this statement, *the use of anesthesia care must be balanced with potential risk of harm from doing pain procedures in sedated patients*. The statement lists procedures that typically do not require anesthesia/sedation

and lists those for which anesthesia care is more likely to be required. The ASA CROSSWALK® comports with this statement. (For more information please see our November 2016 Timely Topic; Anesthesia Care Not Typically Required).

Definition of "Immediately Available" When Medically Directing
This expert consensus document not only offers a definition of "Immediately Available" but also presents guidelines that practices and facilities can use when developing policies to ensure that physician anesthesiologists are "immediately available" when medically directing anesthesia care.

This information is important since per the Centers for Medicare & Medicaid Services (CMS), one of the required elements to report medical direction is that the physician anesthesiologist "*remains physically present and available for immediate diagnosis and treatment of emergencies*" (Medicare Claims Processing Manual, Chapter 12, Section 50C).

Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia
Practices and payers look to this ASA expert consensus document as an authoritative resource. It provides clinically based information on the status of patient's responsiveness, airway, ventilation and cardiovascular function that that assists the reader in determining the patient's level of anesthesia or sedation. It provides definitions of sedation and anesthesia ranging from Minimal Sedation through General Anesthesia.

The document also raises this very salient point, *"Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to rescue patients whose level of sedation becomes deeper than initially intended. Individuals administering Moderate Sedation/Analgesia ("Conscious Sedation") should be able to rescue patients who enter a state of Deep Sedation/Analgesia, while those administering Deep Sedation/Analgesia should be able to rescue patients who enter a state of General Anesthesia."* For additional information of interest to this topic, please review:

- Advisory on Granting Privileges for Deep Sedation to Non Anesthesiologist Physicians
- Statement of Granting Privileges for Administration of Moderate Sedation to Practitioners

The Medical Necessity of Anesthesiology Services American Society of Anesthesiologists' Position Statement
The point of this position statement is clear from its start, *"There is no circumstance when it is considered acceptable for a person to experience emotional or psychological duress or untreated pain amendable to safe intervention while under a physician's care."* The determination of the need for anesthesia care is a clinical judgment to be made by the physician(s) involved in providing care.

Statement of Anesthesia Care for Endoscopic Procedures
While this statement is specific to anesthesia for endoscopic procedures, it matches the Medical Necessity of Anesthesiology Services addressed above. It also makes specific note that patients with a personal history of failed moderate sedation (ICD-10-CM code Z92.83) may require anesthesia care for these procedures even when others may not.

Anesthesiology coding can be nuanced and requires diligent study of the various factors involved. Therefore, it is imperative that you approach your coding and billing practices with care. The information in this Timely Topic hopefully aids in that endeavor.