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2017

ICD-10

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Introduction

Coding systems and claim forms are part of the reality of modern health care. This *Coding and Payment Guide* provides a comprehensive look at the coding and reimbursement systems used by anesthesia service providers. It is organized topically and numerically, and can be used as a comprehensive coding and reimbursement resource and as a quick lookup resource to solve coding problems.

Coding systems grew out of the need for data collection. By having a standard notation for the procedures performed and for the diseases, injuries, and illnesses diagnosed, statisticians could identify effective treatments as well as broad practice patterns. Before long, these early coding systems emerged as the basis to pay claims. Coding systems and claim forms have evolved to become the basis of reimbursement for health care services. The correct application of codes and knowledge of payer policies correlates directly to payment.

The administrative simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 required the standardization of the several hundred health care claim formats previously in existence as well as the establishment of standardized code sets for medical data including diagnoses, drugs, procedures, equipment, and supplies. The goal of the national standards is to reduce the administrative encumbrances of the existing system; simplify the way medical claims are paid, reducing costs; and promote the growth of electronic business in the health care industry.

Coding Systems

Coding systems seek to answer two questions: what was wrong with the patient (i.e., the diagnosis or diagnoses) and what was done to treat the patient (i.e., the procedures or services rendered).

Under the aegis of the federal government, a three-tiered coding system emerged for physician offices and outpatient facilities. *Physicians' Current Procedural Terminology* (CPT®) codes report procedures and physician services and comprises Level I of the system. A second level, known informally as HCPCS Level II, largely report supplies, nonphysician services, and pharmaceuticals. Dovetailing with these two coding systems is the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) classification that reports the diagnosis of illnesses, diseases, and injuries.

Further explanation of each of these coding systems follows.

HCPCS Level I or CPT Codes

The Centers for Medicare and Medicaid Services (CMS), in conjunction with the American Medical Association (AMA), the American Dental Association (ADA), and several other professional groups developed, adopted, and implemented a coding system describing services rendered to patients. Known as HCPCS Level I, the CPT coding system is the most commonly used system to report medical services and procedures. Copyright of CPT codes and descriptions is held by the AMA. This system reports outpatient and provider services.

The three categories of CPT codes predominantly describe medical services and procedures, and are adapted to provide a common billing language that providers and payers can use for payment purposes. The codes are widely used and required for billing by both private and public insurance carriers, managed care companies, and workers' compensation programs. A requirement of HIPAA is that CPT codes are used for the reporting of physician and other health care services.

The AMA's CPT Editorial Panel reviews the coding system and adds, revises, and deletes codes and descriptions. The panel accepts information and feedback from providers about new codes and revisions to existing codes that could better reflect the services or procedures.

The majority of codes are found in category I of the CPT coding system. These five-digit numeric codes describe procedures and services that are customarily performed in clinical practices.

CPT category II codes are supplemental tracking codes that are primarily used when participating in the Physician Quality Reporting System (PQRS) established by Medicare and are intended to aid in the collection of data about quality of care. At the present time, participation in this program is optional and physicians should not report these codes if they elect not to participate. Category II codes are alphanumeric, consisting of four digits followed by an F and should never be used in lieu of a category I CPT code. This series of codes is updated on a biannual basis (January 1 and July 1), with codes that are released becoming effective six months later (e.g., codes released on January 1 become effective July 1). Refer to the AMA CPT website at http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt/category-ii-codes.page.

Category III of the CPT coding system contains temporary tracking codes for new and emerging technologies that are meant to aid in the collection of data on these new services and procedures. Indicated by four numeric digits followed by a T, like category II codes, category III CPT codes are released twice a year (January 1 and July 1) and can be found on the on the AMA CPT website. Relative value units (RVUs) are not assigned for these codes, and payment is made at the discretion of the local payer. Once implemented, a service described by a category III CPT code may eventually become a category I code.

ICD-10-CM Codes

In response to ICD-9-CM's shortcomings, new coding systems were developed and have been implemented in the United States.The World Health Organization (WHO) created and adopted ICD-10 in 1994 and it has been used in much of the world since then. This system is the basis for the new U.S. diagnosis coding system, International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) effective October 1, 2015.

The ICD-10-CM coding system is an alphanumeric system and allows for up to seven digits to be assigned to describe a disease or injury. Generally, the reason the patient seeks treatment should be sequenced first when multiple diagnoses are listed.

Overall, the 10th revision goes into greater clinical detail than ICD-9-CM and addresses information about previously classified diseases, as well as those diseases discovered since the last revision. Conditions are grouped with general epidemiological purposes and the evaluation of health care in mind. New features have been added, and conditions have been reorganized, although the format and conventions of the classification remain unchanged for the most part.

00326

00326 Anesthesia for all procedures on the larynx and trachea in children younger than 1 year of age

Coding Tips

Do not report code 99100 in addition to code 00326. When the patient is older than 1 year of age, see code 00320.

Documentation Tips

Providers should be certain that sufficient documentation is provided in the medical record to accurately verify the description of the services rendered and to support medical necessity of the service. Additionally, records should be legible and signed with the appropriate name and title of the provider of the service.

Reimbursement 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. When both a CRNA and an anesthesiologist are involved in a single case, the documentation must be submitted by both providers to support payment of the full fee for each of the two providers. The physician reports modifier AA and the CRNA reports modifier QZ for a nonmedically directed case. 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

21495, 31300, 31320, 31360, 31367, 31370, 31375, 31380, 31382, 31400, 31420, 31502, 31505, 31510, 31511, 31512, 31513, 31515, 31520, 31525, 31526, 31527, 31528, 31529, 31530, 31531, 31535, 31536, 31540, 31541, 31545, 31546, 31560, 31561, 31570, 31571, 31575, 31576, 31577, 31578, 31579, 31580, 31582, 31584, 31587, 31588, 31590, 31595, 31600, 31601, 31603, 31605, 31610, 31611, 31612, 31613, 31614, 31615, 31622, 31623, 31624, 31625, 31626, 31628, 31629, 31630, 31631, 31635, 31636, 31638, 31640, 31641, 31643, 31645, 31646, 31647, 31648, 31660, 31661, 31730, 31750, 31755, 31760, 31780, 31781, 31785, 31786, 31800, 31805, 31820, 31825, 32701, S2340, S2341

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

Medicare Edits

	Fac RVU	Non-Fac RVU	FUD	Status	MUE
00326	0.0	0.0	N/A	J	-

	Modifiers				Medicare References
00326	N/A	N/A	N/A	N/A	None
* with documentation					

00350

00350 Anesthesia for procedures on major vessels of neck; not otherwise specified

Coding Tips

This code should be used to report anesthesia during a procedure on a major vessel of the neck, such as the internal or external carotid artery or the jugular vein. Code 00350 should not be reported for arteriography. When anesthesia is performed during an arteriography, code 01916 should be reported.

Documentation Tips

Providers should be certain that sufficient documentation is provided in the medical record to accurately verify the description of the services rendered and to support medical necessity of the service. Additionally, records should be legible and signed with the appropriate name and title of the provider of the service.

Reimbursement 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. When both a CRNA and an anesthesiologist are involved in a single case, the documentation must be submitted by both providers to support payment of the full fee for each of the two providers. The physician reports modifier AA and the CRNA reports modifier QZ for a nonmedically directed case. 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

0075T, 0266T, 0267T, 0268T, 0269T, 0270T, 0271T, 31365, 31368, 31390, 31395, 33889, 33891, 33951, 33952, 33953, 33954, 33955, 33956, 33957, 33958, 33959, 33962, 33963, 33964, 33965, 33966, 33969, 33984, 33985, 33986, 33988, 33989, 34001, 34471, 35001, 35002, 35005, 35180, 35188, 35201, 35231, 35261, 35301, 35501, 35506, 35508, 35509, 35510, 35511, 35512, 35515, 35601, 35606, 35612, 35642, 35645, 35691, 35693, 35694, 35695, 35701, 35761, 35800, 35875, 35876, 35901, 36100, 36215, 36216, 36217, 36222, 36223, 36224, 36225, 36226, 37215, 37216, 37217, 37218, 60605

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

Medicare Edits

	Fac RVU	Non-Fac RVU	FUD	Status	MUE
00350	0.0	0.0	N/A	J	-

	Modifiers				Medicare References
00350	N/A	N/A	N/A	N/A	100-4,4,20.6.4; 100-4,4,250.3.3.1
* with documentation					

00539

00539 Anesthesia for tracheobronchial reconstruction

Coding Tips

Report code 00548 for anesthesia during intrathoracic procedures on trachea and bronchi.

Documentation Tips

Providers should be certain that sufficient documentation is provided in the medical record to accurately verify the description of the services rendered and to support medical necessity of the service. Additionally, records should be legible and signed with the appropriate name and title of the provider of the service.

Reimbursement Tips

Routine postoperative evaluation is included in the base unit for the anesthesia service and should not be reported separately or included when determining anesthesia time units. Likewise, postoperative evaluation and management services related to the surgery are not reported separately by the provider unless a significant, separately identifiable ongoing critical care service is rendered.

Surgical to Anesthesia Code Crosswalk

31760, 31766, 31770, 31775, 31780, 31781, 32442, 32486

ICD-10-CM Diagnostic Codes

A15.5	Tuberculosis of larynx, trachea and bronchus
C33	Malignant neoplasm of trachea
C34.01	Malignant neoplasm of right main bronchus
C34.02	Malignant neoplasm of left main bronchus
C34.11	Malignant neoplasm of upper lobe, right bronchus or lung
C34.12	Malignant neoplasm of upper lobe, left bronchus or lung
C34.2	Malignant neoplasm of middle lobe, bronchus or lung
C34.31	Malignant neoplasm of lower lobe, right bronchus or lung
C34.32	Malignant neoplasm of lower lobe, left bronchus or lung
C34.81	Malignant neoplasm of overlapping sites of right bronchus and lung
C34.82	Malignant neoplasm of overlapping sites of left bronchus and lung
C78.01	Secondary malignant neoplasm of right lung
C78.02	Secondary malignant neoplasm of left lung
C7A.090	Malignant carcinoid tumor of the bronchus and lung
D02.1	Carcinoma in situ of trachea
D02.21	Carcinoma in situ of right bronchus and lung
D02.22	Carcinoma in situ of left bronchus and lung
D14.2	Benign neoplasm of trachea
D14.31	Benign neoplasm of right bronchus and lung
D14.32	Benign neoplasm of left bronchus and lung
D38.1	Neoplasm of uncertain behavior of trachea, bronchus and lung
D3A.090	Benign carcinoid tumor of the bronchus and lung
J39.8	Other specified diseases of upper respiratory tract
J98.09	Other diseases of bronchus, not elsewhere classified
J98.4	Other disorders of lung
Q32.0	Congenital tracheomalacia
Q32.1	Other congenital malformations of trachea
Q32.2	Congenital bronchomalacia
Q32.3	Congenital stenosis of bronchus
Q32.4	Other congenital malformations of bronchus
S11.022A	Laceration with foreign body of trachea, initial encounter
S11.024A	Puncture wound with foreign body of trachea, initial encounter
S11.025A	Open bite of trachea, initial encounter
S17.0XXA	Crushing injury of larynx and trachea, initial encounter
S27.311A	Primary blast injury of lung, unilateral, initial encounter
S27.312A	Primary blast injury of lung, bilateral, initial encounter
S27.321A	Contusion of lung, unilateral, initial encounter
S27.322A	Contusion of lung, bilateral, initial encounter
S27.329A	Contusion of lung, unspecified, initial encounter
S27.331A	Laceration of lung, unilateral, initial encounter
S27.332A	Laceration of lung, bilateral, initial encounter
S27.391A	Other injuries of lung, unilateral, initial encounter
S27.392A	Other injuries of lung, bilateral, initial encounter
S27.399A	Other injuries of lung, unspecified, initial encounter
S27.411A	Primary blast injury of bronchus, unilateral, initial encounter
S27.412A	Primary blast injury of bronchus, bilateral, initial encounter
S27.421A	Contusion of bronchus, unilateral, initial encounter
S27.422A	Contusion of bronchus, bilateral, initial encounter
S27.431A	Laceration of bronchus, unilateral, initial encounter
S27.432A	Laceration of bronchus, bilateral, initial encounter
S27.491A	Other injury of bronchus, unilateral, initial encounter
S27.492A	Other injury of bronchus, bilateral, initial encounter
S27.50XA	Unspecified injury of thoracic trachea, initial encounter
S27.51XA	Primary blast injury of thoracic trachea, initial encounter
S27.52XA	Contusion of thoracic trachea, initial encounter
S27.53XA	Laceration of thoracic trachea, initial encounter
S27.59XA	Other injury of thoracic trachea, initial encounter
S28.0XXA	Crushed chest, initial encounter
T27.0XXA	Burn of larynx and trachea, initial encounter
T27.1XXA	Burn involving larynx and trachea with lung, initial encounter
T27.4XXA	Corrosion of larynx and trachea, initial encounter
T27.5XXA	Corrosion involving larynx and trachea with lung, initial encounter

Please note that this list of associated ICD-10-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.

Medicare Edits

	Fac RVU	Non-Fac RVU	FUD	Status	MUE
00539	0.0	0.0	N/A	J	-

	Modifiers				Medicare References
00539	N/A	N/A	N/A	N/A	None

* with documentation

94002-94003

94002 Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day

94003 hospital inpatient/observation, each subsequent day

Explanation

A mechanical ventilator is applied with a mask over the nose and mouth or through a tube placed into the trachea for patients requiring help breathing due to a lung disorder. Intermittent positive pressure breathing uses positive pressure during the inspiration phase of breathing. Code 94002 applies to ventilation assistance using adjustments in volume and pressure on the initial day of treatment in a hospital to an inpatient or observation patient and 94003 is reported for ventilation assistance to a hospital inpatient observation patient provided on subsequent days. Ventilation assistance and management provided to a nursing facility patient is reported with 94004 on a per day basis.

Coding Tips

A physician or other qualified health care provider may bill separately for ventilation management when care plan oversight services (99339, 99340, 99374–99378) are provided by a different provider. Otherwise, ventilation management should not be billed with an evaluation and management service. These procedures are considered an integral part of anesthesia and should not be reported in addition to an anesthesia service (CPT codes 00100–01999).

Documentation Tips

The documentation must be authenticated by the provider rendering the service.

Reimbursement Tips

These procedures are considered an integral part of anesthesia and should not be reported in addition to an anesthesia service (CPT codes 00100–01999).

ICD-10-CM Diagnostic Codes

J80 Acute respiratory distress syndrome
J95.1 Acute pulmonary insufficiency following thoracic surgery
J95.2 Acute pulmonary insufficiency following nonthoracic surgery
J95.3 Chronic pulmonary insufficiency following surgery
J95.821 Acute postprocedural respiratory failure
J95.822 Acute and chronic postprocedural respiratory failure
J95.850 Mechanical complication of respirator
J96.00 Acute respiratory failure, unspecified whether with hypoxia or hypercapnia
J96.01 Acute respiratory failure with hypoxia
J96.02 Acute respiratory failure with hypercapnia
J96.10 Chronic respiratory failure, unspecified whether with hypoxia or hypercapnia
J96.11 Chronic respiratory failure with hypoxia
J96.12 Chronic respiratory failure with hypercapnia
J96.20 Acute and chronic respiratory failure, unspecified whether with hypoxia or hypercapnia
J96.21 Acute and chronic respiratory failure with hypoxia
J96.22 Acute and chronic respiratory failure with hypercapnia
J96.90 Respiratory failure, unspecified, unspecified whether with hypoxia or hypercapnia
J96.91 Respiratory failure, unspecified with hypoxia
J96.92 Respiratory failure, unspecified with hypercapnia
J98.11 Atelectasis
J98.19 Other pulmonary collapse
J98.2 Interstitial emphysema
J98.3 Compensatory emphysema
J98.4 Other disorders of lung
P22.0 Respiratory distress syndrome of newborn
P22.1 Transient tachypnea of newborn
P22.8 Other respiratory distress of newborn
P22.9 Respiratory distress of newborn, unspecified
P27.0 Wilson-Mikity syndrome
P27.1 Bronchopulmonary dysplasia originating in the perinatal period
P27.8 Other chronic respiratory diseases originating in the perinatal period
P27.9 Unspecified chronic respiratory disease originating in the perinatal period
P28.0 Primary atelectasis of newborn
P28.10 Unspecified atelectasis of newborn
P28.11 Resorption atelectasis without respiratory distress syndrome
P28.19 Other atelectasis of newborn
P28.3 Primary sleep apnea of newborn
P28.4 Other apnea of newborn
P28.5 Respiratory failure of newborn
P28.81 Respiratory arrest of newborn
P28.89 Other specified respiratory conditions of newborn
P28.9 Respiratory condition of newborn, unspecified

Please note that this list of associated ICD-10-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.

Medicare Edits

	Fac RVU	Non-Fac RVU	FUD	Status	MUE
94002	2.66	2.66	N/A	A	1(2)
94003	1.9	1.9	N/A	A	1(2)

	Modifiers				Medicare References
94002	N/A	N/A	N/A	80*	None
94003	N/A	N/A	N/A	80*	

* with documentation