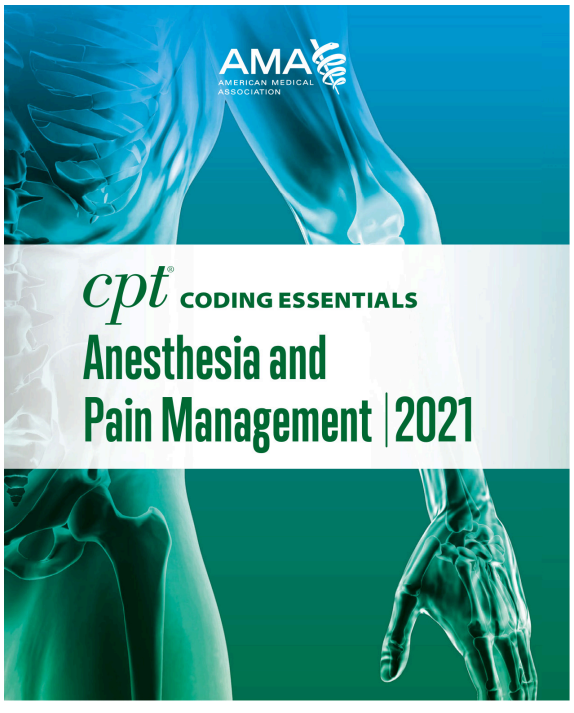


INCLUDES **CPT® TO ICD** CROSSWALKS

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or scan the QR code to access the digital study portal.

Codes List

The CPT surgery and ancillary codes and code ranges that appear in this book are listed below.

Surgery Codes

00100
00102
00103
00104
00120
00124
00126
00140
00142
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00164
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00604
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00630
00632
00635
00640
00670
00700
00702
00730
00731-00732
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00811-00812
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01160
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01173
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01996
20526
20550-20551
20552-20553
20560-20561
20600-20604
20605-20606
20610-20611
27096
28890

36000
36010
36011-36012
36013-36015
36100
36140
36400-36406
36410
36415-36416
36420-36425
36430
36440
36555-36556
36557-36558
36560-36561
36563
36565-36566
36568-36569
36570-36571
36572-36573
36575-36576
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36580-36581
36582-36583
36584-36585
36589-36590
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36620-36625
61050-61055
62270-62272
62273
62280-62282
62284
62290-62291
62302-62305
62320-62323
62324-62327
62328-62329
62350-62351
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62360-62362
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62367-62370
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63650-63655
63661-63662

63663-63664
63685-63688
64400-64405
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64415-64416
64417-64418
64420-64421
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64461-64463
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64590-64595
64600-64610
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64632
64633-64636
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64642-64643
64644-64645
64646-64647
64680
64681

Ancillary Codes

71045-71048
72020

72040-72052
72070-72074
72080
72081-72084
72100-72114
72120
72125-72127
72128-72130
72131-72133
72141-72142
72146-72147
72148-72149
72156-72158
72200-72202
72240-72270
72275
72285
72295
75901
75902
76800
76942
77001
77002
77003
77021
80047-80048
80050
80051
80053
80171
80175
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80203
80305-80307
80323
80329-80331
80332-80334
80335-80337
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80369-80370
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82286
82310
82330
82374
82435
82947-82948
83873
84132
84260
84295-84302
85002
85004
85013-85014
85018
85025-85027
85041
85045-85046
85048
85049
85345
85610-85611
85651-85652
86328
86769
87635
90791-90792
90832-90838
90863
90865
90867-90869
90870
90875-90876
90880
90882
90885
90887
90889
90901
92960-92961
93000-93010
93040-93042
93241-93244
93318
94002-94004
94760-94762
95812-95813
95851-95852
95857
95860-95864
95866
95867-95868
95869
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95872
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95905
95907-95913
95921-95922
95923
95925-95927
95928-95929
95970-95972
95990-95991
96156
96158-96159
96164-96171
96360-96361
96365-96368
96369-96371
96372
96373
96374-96376
97810-97814
99000-99001
99024
99026-99027
99050
99051
99053
99056
99058-99060
99070
99071
99100
99116
99135
99140
99151-99153
99155-99157
99605-99607
0106T-0110T
0213T-0215T
0216T-0218T
0278T
0440T-0442T
0552T

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Introduction

Unlike other specialty coding books on the market, *CPT® Coding Essentials for Anesthesia and Pain Management 2021* combines anesthesia and pain management–specific procedural coding and reimbursement information with verbatim guidelines and parenthetical information from the Current Procedural Terminology (CPT®) codebook. In addition, *CPT® Coding Essentials for Anesthesia and Pain Management 2021* enhances that CPT-specific information by displaying pertinent diagnostic codes, procedural descriptions, illustrations, relative value units (RVUs), and more on the same page as the CPT code being explained. This one book provides anesthesia and pain management coding and billing knowledge that otherwise might take years of experience or multiple resources to accumulate. It sets a foundation for anesthesia and pain management coders and subspecialty coding experts that facilitates correct code assignment.

This book includes reporting rules for CPT code submission as written and enforced by the Centers for Medicare & Medicaid Services (CMS). *CPT® Coding Essentials for Anesthesia and Pain Management 2021* is not intended to equip coders with information to make medical decisions or to determine diagnoses or treatments; rather, it is intended to aid correct code selection that is supported by physician or other qualified health care professional (QHP) documentation. This reference work does not replace the need for a CPT codebook.

IMPORTANT: The RVU file that contains the modifier values for new CPT codes was not released as the CPT Coding Essentials 2021 specialty books went to press. Once the data are available, the file will be available at www.amaproductupdates.com.

The pending RVU modifier data only affect the following codes: 33741, 33745, 33746, 33995, 33997, 57465, 30468, 55880.

About the *CPT® Coding Essentials* Editorial Team and Content Selection

The *CPT® Coding Essentials* series is developed by a team of veteran clinical technical editors and certified medical coders. When developing the content of this book, the team members consider all annual new, revised, and deleted medical codes. They adhere to authoritative medical research; medical policies; and official guidelines, conventions; and rules to determine the final content presented within this book. In addition, the team monitors utilization and denial trends when selecting the codes highlighted in *CPT® Coding Essentials for Anesthesia and Pain Management 2021.*

The main section of the book is titled "CPT® Procedural Coding." This section is organized for ease of use and simple lookup by displaying CPT codes in numeric order. Each code-detail page of this section presents a single code or multiple codes representing a code family concept.

The procedures featured are those commonly performed by an anesthesiologist or pain management specialist, but more difficult to understand or miscoded in claims reporting. This book does not provide a comprehensive list of all services performed in the specialty, nor all sites within impacted body systems. Similarly, the CPT to ICD-10-CM crosswalks are intended to illustrate those conditions that would most commonly present relative to the procedure and the specialist. The crosswalks are not designed to be an exhaustive list of all possible conditions for each procedure, nor medical necessity reasons for coverage.

The "CPT Procedural Coding" section is complemented by other sections that review anesthesia and pain management terminology and anatomy, ICD-10-CM conventions and coding, ICD-10-CM documentation tips, and the ICD-10-PCS procedure coding and format. The appendices contain data from the CMS National Correct Coding Initiative, multiple ICD-10-CM compliant anesthesia and pain management condition documentation checklists, and evaluation and management (E/M) documentation guidelines.

Sections Contained Within This Book

What follows is a section-by-section explanation of *CPT® Coding Essentials for Anesthesia and Pain Management 2021.*

Terminology, Abbreviations, and Basic Anatomy

This section provides a quick reference tool for coders who may come across unfamiliar terminology in medical record documentation. This review of basic terminology displays lists of alphabetized Greek and Latin root words, prefixes, and suffixes associated with anesthesia and pain management.

The combination of root words with prefixes and suffixes is the basis of medical terminology and enables readers to deduce the meaning of new words by understanding the components. For example, *neuro* is a root word for *nerve,* and *–algia* is a suffix for *pain*; thus, *neuralgia* describes nerve pain.

Also included in this section are a glossary of anesthesia and pain management–specific terms and a list of acronyms and abbreviations. Keep in mind that these glossary definitions are specific to anesthesia and pain management. The same word may have a different meaning in a different specialty. In some cases, a parenthetical note after the term may provide the reader with a common acronym or synonym for that term. Pay particular attention to the use of capitalization in the abbreviation and acronym list, as the same letters sometimes have varied meaning in clinical nomenclature, depending on capitalization.

Introduction to ICD-10-CM and ICD-10-PCS

For coders who want a review, *CPT® Coding Essentials for Anesthesia and Pain Management 2021* recaps the development of the ICD-10-CM and ICD-10-PCS code sets and outlines important concepts pertaining to both.

Lists of common ICD-10-CM diagnoses and conditions for each selected CPT code or code range may be found within the "CPT Procedural Coding" section.

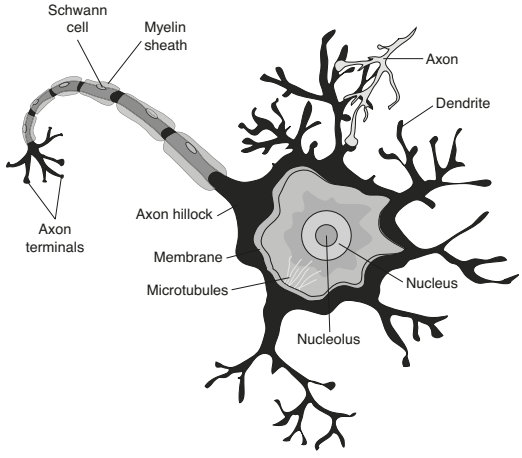
The ICD-10-CM content provided within this book complements your use of the *ICD-10-CM 2021* codebook. This section provides a chapter-by-chapter overview of ICD-10-CM that includes common new diagnoses and their codes, as well as identification of new or substantially changed chapter-specific guidelines for 2021.

ICD-10-PCS is not used for reporting physician services; however, an understanding of ICD-10-PCS is essential to physician practices because physician inpatient surgical documentation is used by hospitals for the abstraction of ICD-10-PCS codes for hospital billing. An overview of this structure is reviewed in this section.

ICD-10-CM Anatomy and Physiology

Advanced understanding of the nervous system, anatomy, and pathophysiology is essential to accurate coding for anesthesia and pain management. A detailed study of the neurological, anatomy and physiology gives beginner or intermediate coders the information boost they may need to abstract the medical record accurately.

Neuron



The anatomy and physiology explanations are accompanied by labeled and detailed illustrations for anesthesia and pain management, beginning at the cellular level and extending to the functions and interactions of the various body parts and tissues. This section also includes discussion of common disorders affecting the nervous system and their pathophysiology, as well as coding exercises to assess mastery of the coding topic.

ICD-10-CM Documentation

Accurate, complete coding of diseases, disorders, injuries, conditions, and even signs and symptoms using ICD-10-CM codes requires extensive patient encounter documentation. This section highlights commonly encountered that require a high level of specificity for documentation and reporting.

The documentation information is presented in an easy-to-understand bulleted format that enables the physician, other QHP, and/or coder to identify quickly the specificity of documentation required for accurate ICD-10-CM code abstraction. This section also includes coding exercises to assess mastery of the documentation topic.

CPT® Procedural Coding

"CPT Procedural Coding" is the main section of this book and displays pertinent coding and reimbursement data for each targeted CPT code or code family on code-detail pages. The following is presented within each surgical code detail page:

- CPT code and verbatim description with icons (when required)
- Parentheticals (when they exist)
- Official CPT coding guidelines
- Plain English descriptions
- Illustrations
- ICD-10-CM diagnostic codes
- AMA *CPT® Assistant* newsletter references
- CMS Pub 100 references
- CMS base units or relative value units
- CMS global periods
- CMS modifier edits

Category III codes and codes from diagnostic (ancillary) sections will contain a truncated version of the code-detail page content, as diagnostic tests are too broad for all data elements contained in the code-detail pages.

CPT Coding Guidelines

The guidelines and parenthetical instructions included in the CPT codebook provide coders with insight into how the CPT Editorial Panel and CPT Advisory Committee intend the codes to be used. This information is critical to correct code selection, and until now, has been unavailable in books other than official AMA CPT codebooks.

Section guidelines for the pertinent sections of the CPT code set (Anesthesia, Surgery, Radiology, Pathology, and Medicine) appear before the code-detail pages associated with the respective CPT section. Guidelines that appear elsewhere within a CPT code set section are displayed on the code-detail page, whenever appropriate. The reproduction of coding guidelines and parenthetical information in *CPT® Coding Essentials for Anesthesia and Pain Management 2021* is verbatim from the AMA CPT codebook.

CPT Codes and Descriptions

CPT codes are listed in numerical order and include anesthesia, surgery, radiology, pathology and laboratory, medicine, and Category III codes pertinent to anesthesia and pain management.

The CPT code set has been developed as stand-alone descriptions of medical services. However, not all descriptions of CPT codes are presented in their complete form within the code set. In some cases, one or more abbreviated code descriptions (known as *child codes*) appear indented and without an initial capital letter.

Such codes refer back to a common portion of the preceding code description (known as a *parent code*) that includes a semi-colon (;) and includes all of the text prior to the semi-colon. An example of this parent–child code system is as follows:

00120 Anesthesia for procedures on external, middle, and inner ear including biopsy; not otherwise specified

00124 otoscopy

00126 tympanotomy

The full descriptions for indented codes 00124 and 00126 are:

00124 Anesthesia for procedures on external, middle, and inner ear including biopsy; otoscopy

00126 Anesthesia for procedures on external, middle, and inner ear including biopsy; tympanotomy

When a group of similar codes is found on a code-detailed page in *CPT® Essentials*, a full description of each code will be displayed.

Icons

Icons on the code-detail page may affect ICD or CPT codes. The male (♂) and female (♀) edit icons are applied to ICD codes. New or revised CPT codes are identified with a bullet (●) or triangle (▲), respectively. The plus sign (✚) identifies add-on codes. Add-on codes may never be reported alone, but are always reported in addition to the main procedure, and should never be reported with modifier 51, *Multiple Procedures*.

A bullet with the numeral 7 within it (❼) is displayed next to ICD-10-CM codes that require a seventh character. Consult the ICD-10-CM codebook for appropriate seventh characters.

The bolt symbol (↯) identifies CPT codes for vaccines pending FDA approval.

The star symbol (★) identifies CPT codes that may be used to report telemedicine services when appended by modifier 95.

The right/left arrows symbol (⇄) identifies where the full range of lateral codes would be appropriate. To conserve space in the *CPT® Coding Essentials* series, we have chosen to use this icon to denote laterality.

The cell phone icon (📱) denotes the *CPT® QuickRef*, a mobile app created by the AMA and available from the App Store and Google Play. The icon indicates that additional dynamic information can be accessed within the app (in-app purchases required).

Parenthetical Information

The CPT code set sometimes provides guidance in the form of a parenthetical note. For example:

(For donor nephrectomy, use 00862)

Code-detail pages include parenthetical instructions specific to both the code and the section within which the code is placed within the CPT code set. Not all codes and/or sections have associated parenthetical notes.

CPT® Assistant References

CPT® Assistant is a monthly newsletter published by the AMA to provide supplemental guidance to the CPT codebook. If a CPT code is the subject of discussion in a past issue of *CPT® Assistant*, the volume and page numbers are noted beneath the code to direct readers to the relevant newsletter archives to keep abreast of compliant coding rules.

Plain English Description

A simple description of what is included in the service represented by each CPT code is provided as a guide for coders to select the correct CPT code while reading the medical record. Not all approaches or methodologies are described in the Plain English Description; rather, the most common approaches or methodologies are provided. In some cases, the description provides an overview to more than one code, as some code-detail pages have multiple codes listed.

Illustrations

Streamlined line drawings demonstrate the anatomical site of the procedure, illustrating the basics of the procedure to assist in code selection. In some cases, not all codes on the code-detail page and not all approaches or methodologies are captured in the single illustration.

Diagnostic Code Crosswalk

ICD-10-CM codes commonly associated with the service represented on the code-detail page are listed with their official code descriptions. These crosswalk codes were selected by trained coding professionals based on their knowledge and experience. The most common and medically related ICD-10-CM codes appropriate to the procedure or services represented on the code-detail pages are provided within space constraints. The intent is not to provide a list of codes that are deemed medically necessary or relate to payment policies.

When a seventh character is required for a code, a bullet with the numeral 7 within it (❼) alerts the coder. Sometimes, a seventh character is appended to a code with only three, four, or five characters. In those cases, "X" placeholders are to be appended to the codes so that only the seventh character must be added. For example, the following ICD-10-CM diagnosis code:

T88.4 Failed or difficult intubation requires a seventh character; therefore, it is displayed with six characters in this manner:

❼T88.4XX Failed or difficult intubation

Within ICD-10-CM, many diagnoses have different codes based on laterality (for example, right plantar nerve, left plantar nerve, unspecified plantar nerve). Due to space constraints, not every laterality code is listed. Rather, a representative code is listed along with an icon indicating that other laterality code versions are available.

The provided crosswalks are not meant to replace your ICD-10-CM codebook. Please consult your manual for all seventh characters needed to complete listed codes and additional laterality choices, as well as ICD-10-CM coding conventions essential to proper use.

Pub 100

CMS Pub 100 (Publication 100-04, "Medicare Claims Processing Manual") is an online resource of federal coding regulations that often relate to CPT coding. If a CPT code or its associated procedure is the topic of discussion in a CMS Pub 100 entry, the Pub 100 reference is noted so that coders may access it at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.

Payment Grids

Information in the payment grids that appear on the code-detail pages comes from CMS. These grids identify the base units used to compute allowable amounts for anesthesia services or the relative value of providing a specific professional service in relation to the value of other services, the number of postoperative follow-up days associated with each CPT code, and other reimbursement edits. All data displayed in the payment grids are relevant to physicians participating in Medicare.

Global Period

During the follow-up, or global surgery period, any routine care associated with the original service is bundled into the original service. This means that, for example, an E/M visit to check the surgical wound would not be billable if it occurs during the global surgery period.

Possible global periods under Medicare are 0, 10, and 90 days. "XXX" indicates that the global period concept does not apply to the service.

Base Units

All anesthesia charges are based on units. Base-unit amounts are published yearly and are based on the complexity of the case and the expected workload of the anesthesia provider required to perform the work. Base units are then added to time units and any modifiers to derive payment.

Relative Value Units (RVUs)

RVU data show the breakout of work, practice expense (PE), and malpractice expense (MP) associated with a code, and provides a breakout for the service depending on whether it was performed in the physician's office or in a facility not belonging to the physician. Understandably, the physician payment for a surgical procedure is reduced if a procedure is hosted by a facility, as the facility would expect payment to cover its share of costs. A physician who performs the surgery in his or her own office is not subject to the same cost-sharing. This cost difference is shown in the PE column.

The payment information provided is sometimes used to set rates or anticipate payments. Payment information may be affected by modifiers appended to the CPT code.

Modifiers

Sometimes, modifiers developed by the AMA and CMS may be appended to CPT codes to indicate that the services represented by the codes have been altered in some way. For example, modifier 26 reports the professional component (PC) of a service that has both a professional and a technical component (TC). A patient who undergoes an ultrasound might have a technician perform the ultrasound itself, while the physician interprets the ultrasound results to determine a diagnosis. The technician's service would be reported with the same ultrasound CPT code as the physician, but the physician would use modifier 26 to indicate the PC only, and the technician would report modifier TC, which is a Healthcare Common Procedure Coding System (HCPCS; pronounced as "hick-picks") Level II modifier identifying the service as the technical portion only. If the physician performs the ultrasound and interprets the results, no modifier is required.

When such circumstances affect the code, users may find the payment information provided for the full code, the professional services–only code, and the technical component–only code.

Many modifiers affect payment for services or with whom payment is shared when multiple providers or procedures are involved in a single surgical encounter. CMS provides definitions for the payments, based on the number listed in the modifier's field.

Modifier 50 (Bilateral Procedure)

This modifier indicates which payment-adjustment rule for bilateral procedures applies to the service.

0 150% payment adjustment for bilateral procedures does not apply. If a procedure is reported with modifier 50 or with modifiers RT and LT, Medicare bases payment for the two sides on the lower of (a) the total actual charge for both sides or (b) 100% of the fee-schedule amount for a single code. For example, the fee-schedule amount for code XXXXX is $125. The physician reports code XXXXX-LT with an actual charge of $100 and XXXXX-RT with an actual charge of $100.

Payment would be based on the fee-schedule amount ($125) because it is lower than the total actual charges for the left and right sides ($200). The bilateral adjustment is inappropriate for codes in this category (a) due to physiology or anatomy or (b) because the code descriptor specifically states that it is a unilateral procedure and there is an existing code for the bilateral procedure.

1 150% payment adjustment for bilateral procedures applies. If a code is billed with the bilateral modifier or is reported twice on the same day by any other means (such as with RT and LT modifiers or with a "2" in the units field), payment is based for these codes when reported as bilateral procedures on the lower of (a) the total actual charge for both sides or (b) 150% of the fee-schedule amount for a single code. If a code is reported as a bilateral procedure and is reported with other procedure codes on the same day, the bilateral adjustment is applied before any applicable multiple procedure rules are applied.

2 150% payment adjustment for bilateral procedure does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. If a procedure is reported with modifier 50, or is reported twice on the same day by any other means (such as with RT and LT modifiers with a "2" in the units field), payment is based for both sides on the lower of (a) the total actual charges by the physician for both sides, or (b) 100% of the fee-schedule amount for a single code. For example, the fee-schedule amount for code YYYYY is $125. The physician reports code YYYYY-LT with an actual charge of $100 and YYYYY-RT with an actual charge of $100.

Payment would be based on the fee-schedule amount ($125) because it is lower than the total actual charges for the left and right sides ($200). The RVUs are based on a bilateral procedure because (a) the code descriptor specifically states that the procedure is bilateral, (b) the code descriptor states that the procedure may be performed either unilaterally or bilaterally, or (c) the procedure is usually performed as a bilateral procedure.

3 The usual payment adjustment for bilateral procedures does not apply. If a procedure is reported with modifier 50, or is reported for both sides on the same day by any other means (such as with

RT and LT modifiers or with a "2" in the units field), Medicare bases payment for each side or organ or site of a paired organ on the lower of (a) the actual charge for each side or (b) 100% of the fee-schedule amount for each side. If a procedure is reported as a bilateral procedure and with other procedure codes on the same day, the fee-schedule amount for a bilateral procedure is determined before any applicable multiple procedure rules are applied. Services in this category are generally radiology procedures or other diagnostic tests that are not subject to the special payment rules for other bilateral procedures.

9 Concept does not apply.

Modifier 51 (Multiple Procedures)

This modifier indicates which payment-adjustment rule for multiple procedures applies to the service.

0 No payment-adjustment rules for multiple procedures apply. If the procedure is reported on the same day as another procedure, payment is based on the lower of (a) the actual charge or (b) the fee-schedule amount for the procedure.

1 This indicator is only applied to codes with a procedure status of "D." If a procedure is reported on the same day as another procedure with an indicator of "1," "2," or "3," Medicare ranks the procedures by the fee-schedule amount, and the appropriate reduction to this code is applied (100%, 50%, 25%, 25%, 25%, and by report). Carriers and Medicare Administrative Contractors (MACs) base payment on the lower of (a) the actual charge or (b) the fee-schedule amount reduced by the appropriate percentage.

2 Standard payment-adjustment rules for multiple procedures apply. If the procedure is reported on the same day as another procedure with an indicator of "1," "2," or "3," carriers and MACs rank the procedures by the fee-schedule amount and apply the appropriate reduction to this code (100%, 50%, 50%, 50%, 50%, and by report). MACs base payment on the lower of (a) the actual charge or (b) the fee-schedule amount reduced by the appropriate percentage.

3 Special rules for multiple endoscopic procedures apply if a procedure is billed with another endoscopy in the same family (ie, another endoscopy that has the same base procedure). The base procedure for each code with this indicator is identified in field 31G of Form CMS-1500 or its electronic equivalent claim. The multiple endoscopy rules apply to a family before ranking the family with other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). If an endoscopic procedure is reported with only its base procedure, the base procedure is not separately paid. Payment for the base procedure is included in the payment for the other endoscopy.

4 Diagnostic imaging services are subject to multiple procedure payment reduction (MPPR) methodology. Technical component (TC) of diagnostic imaging services are subject to a 50% reduction of the second and subsequent imaging services furnished by the same physician (or by multiple physicians in the same group practice using the same group national provider identifier [NPI]) to the same beneficiary on the same day, effective for services July 1, 2010, and after. Physician component (PC) of diagnostic imaging services are subject to a 25% payment reduction of the second and subsequent imaging services effective January 1, 2012.

5 Selected therapy services are subject to MPPR methodology. Therapy services are subject to 20% of the practice expense component for certain therapy services furnished in office or other non-institutional settings, and a 25% reduction of the PE component for certain therapy services furnished in institutional settings. Therapy services are subject to 50% reduction of the PE component for certain therapy services furnished in both institutional and non-institutional settings.

6 Diagnostic services are subject to the MPPR methodology. Full payment is made for the TC service with the highest payment under the Medicare physician fee schedule (MPFS). Payment is made at 75% for subsequent TC services furnished by the same physician (or by multiple physicians in the same group practice using the same group NPI) to the same beneficiary on the same day.

7 Diagnostic ophthalmology services are subject to the MPPR methodology. Full payment is made for the TC service with the highest payment under the MPFS. Payment is made at 80% for subsequent TC services furnished by the same physician (or by multiple physicians in the same group practice using the same group NPI) to the same beneficiary on the same day.

9 Concept does not apply.

Modifier 62 (Two Surgeons)

This modifier indicates services for which two surgeons, each in a different specialty, may be paid.

0 Co-surgeons not permitted for this procedure.

1 Co-surgeons could be paid. Supporting documentation is required to establish medical necessity of two surgeons for the procedure.

2 Co-surgeons permitted. No documentation is required if two specialty requirements are met.

9 Concept does not apply.

Modifier 66 (Surgical Team)

This modifier indicates services for which a surgical team may be paid.

0 Team surgeons not permitted for this procedure.

1 Team surgeons could be paid. Supporting documentation is required to establish medical necessity of a team; paid by report.

2 Team surgeons permitted; paid by report.

9 Concept does not apply.

Modifier 80 (Assistant Surgeon)

This modifier indicates services for which an assistant at surgery is never paid.

0 Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity.

1 Statutory payment restriction for assistants at surgery applies to this procedure. Assistants at surgery may not be paid.