

Case 1

<u>CRNA performed anesthesia</u>	1.
<u>Anesthesiologist medically directing two cases</u>	2.
Anesthesia Time: 9:30 to 10:06	
<u>Physical Status 3</u>	3.
Preoperative diagnosis: Cyst on knee	
Postoperative diagnosis: <u>Baker's Cyst</u>	4.
Procedure: <u>Excision of Baker's Cyst, knee</u>	5.
Anesthesia: <u>Monitored Anesthesia Care</u>	6.

1. Use Modifier QX to indicate CRNA services with medical direction by a physician.
2. Use modifier QK to indicate medical direction of two cases.
3. Physical status 3—use P3 modifier.
4. Use post-operative diagnosis.
5. Excision is an open procedure and is performed on the knee.
6. MAC services require QS modifier.

What are the CPT® and ICD-9-CM Codes reported for the Anesthesiologist?

CPT® Codes: 01400-QK-QS-P3

ICD-9-CM Code: 727.51

What are the CPT® and ICD-9-CM Codes reported for the CRNA?

CPT® Code: 01400-QX-QS-P3

ICD-9-CM Code: 727.51

What is the time reported for this service?

36 minutes

RATIONALE: CPT® codes: Look in the CPT® Index for Anesthesia/Knee. You are referred to a large selection of codes. Other than 00400 (used for Integumentary), the codes directed fall within the range 01320–01444 (Knee and Popliteal Area). An excision is an open procedure, so you would find the code specific to open procedures on the knee. There is not a specific anesthesia code for excision of a Baker's cyst, so CPT® 01400 is reported. The physical status is reported as level 3 (P3). QK is used to indicate the anesthesiologist is directing 2–4 concurrent cases. QX is used to indicate the services reported by the CRNA. QS reports Monitored Anesthesia Care (MAC) services.

ICD-9-CM code: The post-operative diagnosis is Baker's Cyst. In the ICD-9-CM Index to Diseases, you can either look for Baker's/cyst (knee) or Cyst/Baker's (knee), both options direct you to 727.51.

Time: The anesthesia time is noted as 9:30–10:06, which is 36 minutes.

Case 2

1. Anesthesiologist personally performed

2. Anesthesia Time: 7:12 to 10:08

3. Physical Status 2

Preoperative diagnosis: Suspected Prostate Cancer

4. **Postoperative diagnosis:** Prostate Carcinoma

5. **Procedure:** Radical Retropubic Prostatectomy

6. **Anesthesia:** General

1. Personally performed by anesthesiologist—use AA modifier.

2. Time is 176 minutes.

3. Physical status 2, use P2 modifier.

4. Post-operative diagnosis 185.

5. Procedure performed. Make note the procedure is “radical.”

6. General anesthesia.

What are the CPT® and ICD-9-CM Codes reported for the Anesthesiologist?

CPT® Code: 00865-AA-P2

ICD-9-CM Code: 185

What is the time reported for this service?

176 minutes

RATIONALE: CPT® code: The procedure performed is a radical retropubic prostatectomy. The prostate is considered extraperitoneal in the lower abdomen. Look in the CPT® Index for Anesthesia/Prostatectomy/Radical which refers you to CPT® 00865. P2 is used to report the physical status level 2. AA is used to report the anesthesiologist personally performed the anesthesia.

ICD-9-CM code: In the Neoplasm Table, look for Prostate. Carcinoma indicates a malignancy. ICD-9-CM code 185 from the primary malignancy column is reported.

Time: The start time is 7:12. The end time is 10:08. This calculates to 2 hours and 56 minutes, or 176 minutes.

Case 3

Non-medically directed CRNA performed anesthesia and documented intra-operative placement of continuous femoral nerve catheter for post operative pain. 1. 2.

Anesthesia Time: 7:18 to 9:10 3.

Physical Status 3 4.

Preoperative diagnosis: Left Knee Osteoarthritis

Postoperative diagnosis: Left Knee Osteoarthritis, localized primary, Acute post-operative pain 5. 6.

Procedure: Total knee arthroplasty 7.

Anesthesia: General anesthesia provided for surgery, Surgeon requested post-operative pain management via continuous femoral catheter 8.

What are the CPT® and ICD-9-CM Codes reported for the CRNA?

CPT® Codes: 01402-QZ-P3, 64448-59

ICD-9-CM Codes: 715.16, 338.18

What is the time reported for this service?

112 minutes

RATIONALE: CPT® codes: Look in the CPT® Index under Anesthesia/Arthroplasty/ Knee and you are directed to CPT® 01402. P3 indicates a physical status level 3. Modifier QZ is used to indicate the services were performed by a CRNA without medical direction.

The intra-operative placement of continuous femoral nerve catheter is separate from the general anesthesia used for the surgery; therefore, it is reported separately. The catheter is placed for management of the post-operative pain via continuous femoral catheter. To find the CPT® code to report this, look in the index under Femoral Nerve/Injection/Anesthetic, this directs you to 64447–64448. CPT® code 64448 is for the continuous infusion by catheter and includes the catheter placement, so a separate code for the placement would not be reported. Modifier 59 is appended to indicate it is a separate procedure from the general anesthesia used for the surgery.

ICD-9-CM codes: The diagnosis for the general anesthesia is Left Knee Osteoarthritis, localized, primary. Look in the ICD-9-CM Index to Diseases under Osteoarthritis/localized/primary to find 715.1, then select the fifth digit 6 for the knee (lower leg).

Time: The start time is 7:18, the end time is 9:10. This calculates to 1 hour 52 minutes, or 112 minutes.

1. CRNA services without medical direction require modifier QZ.
2. Anesthesia and intra-operative placement of continuous femoral nerve catheter.
3. Time calculates to 1 hour 52 minutes, or 112 minutes.
4. Physical status 3 requires P3 modifier.
5. Primary diagnosis is specified as Left Knee Osteoarthritis, localized, primary.
6. Diagnosis of Acute post-operative pain gives medical necessity for the intra-operative placement of continuous femoral nerve catheter.
7. The procedure is total knee arthroplasty NOT Arthroscopy, which carries a lower base value.
8. Anesthesia provided is general.

Case 4

1. Total anesthesia time 3 hours 26 minutes, or 206 minutes.
2. Physical status 3, use modifier P3.
Personally performed by the anesthesiologist, use modifier AA.
3. Post-operative diagnosis of lumbar (L4-L5) stenosis.
4. The following procedures were performed: L4-5 laminectomy, removal of synovial cyst, bilateral medial facetectomy and posterolateral fusion L4-L5 with vertebral autograft, bone morphogenic protein, chip allograft, all with intraoperative somatosensory evoked potentials, electromyographies and loupe magnification. The Laminectomy is more complex and carries a higher base value.
5. Type of anesthesia is general.

1. Anesthesia Start: 14:07 Anesthesia End: 17:33

2. Physical Status 3 Anesthesiologist: Michael D, MD

Operative Report

Preoperative diagnosis: Lumbar spinal stenosis

3. Postoperative diagnosis: L4-L5 spinal stenosis

Procedure:

L4-L5 laminectomy, removal of synovial cyst, bilateral medial facetectomy and posterolateral fusion L4-L5 with vertebral autograft, bone morphogenic protein, chip allograft, all with intraoperative somatosensory evoked potentials, electromyographies and loupe magnification.

4. magnification.

5. Anesthesia: General endotracheal anesthesia.

Description of Procedure:

The patient was taken to the operating room and underwent intravenous anesthetic and orotracheal intubation. Her head was placed in the three-pin Mayfield headrest. She was turned into the prone position on a four-poster frame. All pressure points were carefully padded. The fluoroscope was brought in and sterilely draped to help localize the incision.

A midline incision was made between L4 and L5 through skin and subcutaneous tissue and the paraspinal muscles were dissected free of the spinous process, lamina, facets and L4, L5 transverse processes. Self-retainers were placed more deeply. We proceeded to use the double-action rongeur to remove the L4-L5 spinous process lamina. 3 and 4 millimeter Kerrison punches were used to complete the laminectomy including removing the hypertrophied ligamentum flavum. We made sure that we decompressed from the top of the L4 pedicle to the bottom of the L5 pedicle, which was confirmed with intraoperative fluoroscopy. The medial facets were drilled and then we undercut over the nerve roots with a 3 millimeter Kerrison punch. Hemostasis was achieved with powdered Gelfoam. We irrigated the wound. We decorticated the L4 and L5 transverse processes. We placed our vertebral autograft, bone morphogenic protein and chip allograft in the posterolateral gutters. Hemovac drain was placed. We closed the muscle with 0 Vicryl. Fascia was closed with 0 Vicryl. Subcutaneous tissue was closed with 2-0 Vicryl and the skin was closed with staples.

What are the CPT® and ICD-9-CM Codes reported for the Anesthesiologist?

CPT® Code: 00630-AA-P3

ICD-9-CM Code: 724.02

What is the time reported for this service?

206 minutes.

RATIONALE: CPT® code: The following procedures were performed: L4–L5 laminectomy, removal of synovial cyst, bilateral medial facetectomy and posterolateral fusion L4–L5 with vertebral autograft, bone morphogenic protein, chip allograft, all with intraoperative somatosensory evoked potentials, electromyographies and loupe magnification. According to the CPT® Index, Anesthesia/Spine and Spinal Cord/Lumbar refers you to codes 00630–00635, 00640, 00670. The most complex procedure performed is the laminectomy which is reported with 00630 *Anesthesia for procedures in lumbar region; not otherwise specified*. Modifier AA is used to indicate the anesthesia service was personally performed by the Anesthesiologist. Modifier P3 is used to indicate a level 3 Physical Status. Anesthesia modifiers always precede physical status modifiers.

ICD-9-CM code: The postoperative diagnosis is L4–L5 Spinal Stenosis. L4–L5 is located in the lumbar region. To locate the ICD-9-CM code, look in the Index to Diseases for Stenosis/spinal/lumbar. There is no indication of neurogenic claudication, so ICD-9-CM code 724.02 is reported.

Time: The start time is 14:07 (2:07 pm) and the end time is 17:33 (5:33 pm). This time calculates to 3 hours and 26 minutes, or 206 minutes.

Case 5

CRNA directly supervised by anesthesiologist who is directing two other cases. 1.

CRNA inserted Swan-Ganz catheter, a separate CVP, and an A-line 2.

Patient has a severe systemic disease that is a constant threat to life 3.

Anesthesia Time: 11:43 to 15:26 4.

Preoperative diagnosis: Multivessel coronary artery disease.

Postoperative diagnosis: Coronary artery disease, native artery 5.

Name of procedure: Coronary artery bypass graft x 3, left internal mammary artery to the LAD, saphenous vein graft to the obtuse marginal, saphenous vein graft to the diagonal.

Anesthesia: General 6.

Brief history: This 77-year-old patient who was found to have a huge aneurysm. Preoperative cardiac clearance revealed a markedly positive stress test and cardiac catheterization showed critical left-sided disease. Coronary revascularization was recommended. The patient has multiple medical illnesses including chronic obstructive pulmonary disease with emphysema and chronic renal insufficiency. I discussed with the patient and the family, the risks of operation including the risk of bleeding, infection, stroke, blood transfusion, renal failure, and death. At operation, we harvested a vein from the left leg using an endoscopic technique that turned out to be a very good conduit. Her obtuse marginal vessel was a 1.5 mm diffusely diseased vessel that was bypassed distally as it ran in the left ventricular muscle. The diagonal was a surprisingly good vessel at 1.5 mm in size. The

1. CRNA directly supervised by the Anesthesiologist supports modifier QX.
- Anesthesiologist was directing two cases, this supports the use of modifier QK.
2. Swan-Ganz is reported separately by the CRNA.
- CVP is reported separately by the CRNA.
- A-line (Arterial line) is reported separately by the CRNA.
3. Supports modifier P4 for physical status 4.
4. Time calculates to 3 hours 43 minutes or 223 minutes.
5. Post-operative diagnosis should be used for diagnosis reporting.
6. Anesthesia is general.

LAD was bypassed in the mid aspect of the LAD and there was distal disease though a 1.5 mm probe passed quite easily. Good flow was measured in the graft. The patient came off bypass very nicely. Note should be made that her ascending aorta was calcified and we used a single clamp technique.

Description of Operative Procedure: Following delivery of the patient to the operating room, the patient was placed under general anesthetic, was prepped and draped in the usual sterile manner. **Arterial line, Right Pulmonary Artery Catheter and a Left Subclavian central lines were placed by the Anesthesia Department.** A median sternotomy was made and the left internal mammary artery was harvested from the left chest wall, the saphenous vein was harvested from the left leg. The patient was heparinized and cannulated and placed on **cardiopulmonary bypass** with an aortic cannula on the undersurface of the aortic arch and a venous cannula through the right atrial sidewall. Note should be made that the upper aorta was very heavily calcified, but the area that we cannulated was felt to be disease free. The aorta was cross clamped and the heart was stopped with antegrade and retrograde cardioplegic solution. The heart was retracted out of the pericardial sac and then displaced into the right chest which afforded good access to the lone marginal vessel which was bypassed with a reversed saphenous vein graft using a running 7-0 Prolene suture. Cold cardioplegic solution was then instilled down this graft. Note should be made that during the mammary artery harvest, the left lung was completely adherent to the left chest wall, most likely from old episodes of pneumonia. Next, a second saphenous vein segment was placed to the diagonal vessel and then the left internal mammary artery was placed to the mid LAD. As noted, there was diffuse calcification distally in this artery just beyond the anastomosis, but the 1.5 mm probe passed very nicely and we felt that it was not necessary to double jump this LAD. With the cross clamp in place, two proximal aortotomies were made and the two proximal anastomoses were formed using 6-0 Prolene in a running fashion. Just prior to completion of the second anastomosis, appropriate de-airing maneuvers were performed and then the suture lines were tied as the cross clamp was removed. The patient was allowed to rewarm completely and was weaned from bypass. The cannulas were removed and the cannulation sites were secured with pursestring sutures. Once hemostasis was secured, chest tubes were placed and the wound was closed. Final needle, instrument, and sponge counts were reported as correct. The patient tolerated the procedure well and returned to the recovery room in stable condition.

7. Verifies line placement by the Anesthesiology department.

8. A bypass machine was used indicating the "pump oxygenator."

7.

8.

What are the CPT® and ICD-9-CM Codes reported for the Anesthesiologist?

CPT® Code: 00567-QK-P4, 99100

ICD-9-CM Code: 414.01

What are the CPT® and ICD-9-CM Codes reported for the CRNA?

CPT® Codes: 00567-QX-P4, 93503, 36620, 36556-59

ICD-9-CM Code: 414.01

What is the time reported for this service?

223 minutes

RATIONALE: CPT® codes: The procedure performed was a CABG (Coronary Artery Bypass Graft). To locate the service in the CPT® Index, look under Anesthesia/Heart/Coronary Artery Bypass Grafting and you are directed to 00566, 00567. Selecting between the two codes depends on the use of a pump oxygenator. The documentation states "...the patient was placed on a cardiopulmonary bypass..." indicating with pump oxygenator. 00567 is the correct anesthesia code. The patient is identified as having severe systemic disease that is a constant threat to life, supporting a P4 modifier.

For the CRNA, modifier QX is used to report the CRNA service with medical direction. Anesthesia modifiers precede physical status modifiers. The CRNA also inserted a Swan-Ganz catheter in the right pulmonary artery (93503) and placed a central venous catheter in the left subclavian (36556). Anesthesia modifiers are not used on surgical procedure codes. A central line 36556 is bundled with 93503. A Swan-Ganz catheter is a central line with multiple lumens which is flow-directed into the pulmonary artery. Modifier 59 is required with 36556 to indicate that this central line is in another site and totally separate from 93503. Code 93503 is modifier 51 exempt. The CRNA also inserted an A-Line (arterial line) which is coded separately with 36620.

For the anesthesiologist, modifier QK indicates the medical direction of 2–4 concurrent cases. The anesthesia modifiers precede physical status modifiers. Code 99100 is also reported due to the patient being 77-years-old.

ICD-9-CM code: The diagnosis is stated as Coronary Artery Disease, Native Artery. To find the ICD-9-CM code, look in the Index to Diseases under Disease/artery/coronary and you are directed to "see Arteriosclerosis, coronary." Looking under Arteriosclerosis/coronary (artery)/native artery, you are directed to 414.01.

Time: The anesthesia time is stated as 11:43 to 15:26 (3:26 pm), which calculates to 3 hours 43 minutes, or 223 minutes.

Case 6

1. QX (CRNA service with medical direction by a physician).
2. QK (Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individual).
3. Anesthesia time is 42 minutes.
4. Physical status 1, musee modifier P1.
5. Postoperative diagnosis is used for coding.
6. Circumcision (6 month old child, don't forget about age Qualifying Circumstances).
7. Monitored Anesthesia Care (Requires QS modifier.).

1. CRNA performed anesthesia under medical direction of anesthesiologist
 2. Anesthesiologist medically directing three cases
 3. Anesthesia time: 8:52 to 9:34
 4. Physical status 1
- Preoperative diagnosis:** Phimosis, congenital
5. Postoperative diagnosis: Phimosis, congenital
 6. Procedure: Circumcision on six-month-old boy
 7. Anesthesia: Monitored anesthesia care

What are the CPT® and ICD-9-CM Codes reported for the Anesthesiologist?

CPT® Codes: 00920-QK-QS-P1, 99100

ICD-9-CM Code: 605

What are the CPT® and ICD-9-CM Codes reported for the CRNA?

CPT® Code: 00920-QS, QX, P1

ICD-9-CM Code: 605

What is the time reported for this service?

42 Minutes

RATIONALE: CPT® codes: The procedure is circumcision. Look in the CPT® Index under Anesthesia for Genitalia/male and you are directed to code range 00920–00938. There is not a code specific to circumcision, so 00920 *Anesthesia for procedures on male genitalia* is used. The patient is 6-months-old so you would add the qualifying circumstance for extreme age (99100). The qualifying circumstance is only reported for the physician. The physical status is stated as 1, so modifier P1 is appended. Modifier QS is appended to indicate Monitored Anesthesia Care (MAC). Modifier QK is appended to the anesthesiologist's code to indicate medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals. Modifier QX is appended to the CRNA's services to indicate the CRNA is performing under the medical direction of an anesthesiologist. The anesthesia modifier is placed first, followed by QS, with the physical status modifier placed last.

ICD-9-CM Code: The diagnosis is phimosis. Look in the ICD-9-CM Index to Diseases for phimosis (congenital) and you are directed to code 605. Verification of this code in the Tabular List confirms code selection.

Time: The anesthesia time is noted as 8:52–9:34, which is 42 minutes.

Case 7

CRNA performed anesthesia under medical direction of anesthesiologist	1.
Anesthesiologist medically directing one case	2.
CRNA placed arterial line	3.
Anesthesia Time: 10:43 to 12:50	4.
Physical Status 3	5.
Preoperative Diagnosis: Left Renal Mass	
Postoperative Diagnosis: Same	6.
Procedure: Left Partial Nephrectomy, Laparoscopic	7.

Anesthesia: General

Procedure Description: Abdominal wall insufflated. The laparoscope was placed through the umbilical port and additional trocars were placed into the abdominal cavity. Using the fiberoptic camera, the renal mass was identified and the diseased kidney tissue was removed using electrocautery. Minimal bleeding is noted. Instruments were removed and the abdominal incisions were closed by suture. Patient tolerated surgery well and was transferred to the Post Anesthesia Care Unit in satisfactory condition.

1. QX (CRNA with medical direction by a physician).
2. QY (medical direction of one CRNA by an anesthesiologist).
3. 36620 - Arterial line placed by CRNA.
4. Time reported is 2 hours 7 minutes or 127 minutes.
5. Use physical status modifier P3.
6. Postoperative diagnosis is the same as the preoperative diagnosis—Left Renal Mass.
7. Procedure performed.

What are the CPT® and ICD-9-CM Codes reported for the Anesthesiologist?

CPT® Code: 00862-QY-P3

ICD-9-CM Code: 593.9

What are the CPT® and ICD-9-CM Codes reported for the CRNA?

CPT® Codes: 00862-QX-P3, 36620

ICD-9-CM Code: 593.9

What is the time reported for this service?

2 hours and 7 minutes, or 127 minutes

RATIONALE: CPT® codes: Look in the CPT® Index for Anesthesia/nephrectomy and you are guided to 00862. Verification of the code confirms this code is for anesthesia for renal procedures. The anesthesiologist was medically directing one CRNA; therefore, QY is appended to 00862. The medically directed CRNA service is reported with modifier QX. The anesthesia modifiers always precede the physical status modifier. The CRNA also inserted an A-Line (arterial line) which is coded separately with 36620.

ICD-9-CM Code: The post operative diagnosis is Kidney Mass (Do not code mass as neoplasm—coding instructions indicate to see disease of specified organ when not

listed under mass). Look in the ICD-9-CM Index for Mass/kidney and you are directed to 593.9.

Time: The start time is listed as 10:43. The end time is listed as 12:50. This calculates to 2 hours and 7 minutes or 127 minutes.

Case 8

1. Use modifier AA to indicate the Anesthesiologist personally performed the case.
2. Anesthesia time is 37 minutes.
3. Physical status 3 - use P3 modifier.
4. Post-operative diagnosis confirms RLL CA.
5. Procedure performed.
6. Use modifier QS to indicate monitored anesthesia care was used.

1. Anesthesiologist personally performed case

2. Anesthesia time: 13:04 to 13:41

3. Physical status 3

Preoperative diagnosis: RLL Lung Cavity, possible CA of lung

4. Postoperative diagnosis: Right Lower Lobe Lung Carcinoma

5. Procedure: Bronchoscopy

6. Anesthesia: Monitored anesthesia care

Procedure description: With the patient under satisfactory anesthesia, a flexible fiberoptic bronchoscope was introduced via oral cavity and advanced past the larynx for visualization of the bronchus. Cell washings were obtained and sent to pathology. The bronchoscope was then removed. Patient tolerated procedure well.

Cell washings obtained from the right lower lobe were confirmed by pathology as malignant carcinoma.

What are the CPT® and ICD-9-CM Codes reported for the Anesthesiologist?

CPT® Code: 00520-AA-QS-P3

ICD-9-CM Code: 162.5

What is the time reported for this service?

37 minutes.

RATIONALE: CPT® code: Look in the CPT® Index under Anesthesia/Bronchoscopy and you are directed to code 00520. Modifier AA is used to indicate the anesthesia service was personally performed by the anesthesiologist. Modifier QS is used to indicate MAC was used. Modifier P3 is used to indicate the patient is physical status 3. Anesthesia modifiers are always listed first, followed by the MAC modifier QS. Physical status modifiers are listed last.

ICD-9-CM code: The diagnosis is confirmed as RLL CA, look in the Neoplasm Table for lung/lower lobe and the Malignant, Primary column indicates 162.5 is the correct code.

Time: The start time is 13:04. The end time is 13:41. The time calculates to 37 minutes.

Case 9

Anesthesia services personally provided by Anesthesiologist

1.

Physical Status 2

2.

Anesthesia Start: 10:03—Anesthesia Stop: 11:06

3.

Preoperative diagnosis: Sternal wound hematoma.

Postoperative diagnosis: Complicated upper abdominal wall wound.

4.

Name of procedure: Sternal wound exploration and wound vac placement.

5.

Anesthesia: Monitored Anesthesia Care

6.

Brief history: He is a 52-year-old patient who is two weeks out from re-do sternotomy and aortic valve replacement for critical aortic stenosis in the setting of heart failure. He had a postoperative coagulopathy and required sternal re-exploration with open packing.

7.

He was closed the next day. He had serous discharge prior to going home but this was culture negative and the wound looked very good. He continued to have serous discharge in the clinic and it was felt he had a retained hematoma. He was scheduled for evaluation of the hematoma and wound vac placement. This was done without incident. He did not have any evidence of infection. There was no evidence of any sternal instability.

Description of operative procedure: Following delivery of the patient to the operating room, the patient was placed on the operating table, prepared and draped in the usual sterile manner. His upper abdominal wound was explored. There was hematoma at the base of the wound which was very carefully evacuated and the wound was irrigated with antibacterial solution. A wound vac was then placed with the assistance of the wound care nurse. The patient was returned to the PCU in stable condition.

9.

1. Use modifier AA to indicate the anesthesia was personally performed by the anesthesiologist.
2. Physical status 2, use modifier P2.
3. Anesthesia time is 1 hour and 3 minutes, or 63 minutes.
4. Postoperative diagnosis used for coding if no other indication is found in the operative note.
5. Procedure performed.
6. Use modifier QS to indicate MAC is used.
7. The wound is a post-operative complication.
8. Confirms a postoperative hematoma.
9. Wound vac placed by a wound care nurse.

What are the CPT® and ICD-9-CM Codes reported for the Anesthesiologist?

CPT® Code: 00700-AA-QS-P2

ICD-9-CM Code: 998.12

What is the time reported for this service?

63 minutes.

RATIONALE: CPT® code: In the CPT® Index, look for Anesthesia/Abdomen, Abdominal Wall and you are directed to a range of codes. This is an upper abdominal wound from a sternal (anterior) procedure. 00700 *Anesthesia for procedures on upper anterior abdominal wall* is the correct code. Anesthesia modifier AA indicates that the anesthesiologist personally performed the anesthesia care. Anesthesia modifiers are always placed first. The QS modifier indicates MAC, and the physical status P2 is listed last.

ICD-9-CM code: The diagnosis is listed as a complicated abdominal wound; however, the body of the note indicates it is a retained hematoma from the procedures two

weeks prior. Look in the ICD-9-CM Index to Diseases for Hematoma/postoperative and you are guided to 998.12.

Time: The start time is 10:03. The end time is 11:06. This calculates to 1 hour and 3 minutes, or 63 minutes.

1. Time reported is 1 hour 13 minutes, or 73 minutes.

2. Modifier QZ used to indicate services are performed by a CRNA with no medical direction.

3. Physical status 3—use modifier P3.

4. Postoperative diagnosis is the same as preoperative which is stricture of the left ureter, postoperative.

5. Modifier QS is used to indicate MAC.

Case 10

1.

Anesthesia start: 12:18

2.

Anesthesia end: 13:31

3.

CRNA: John Sleep, CRNA (Non-Medically Directed)

4.

ASA Physical status-III

Operative Report

Preoperative diagnosis: Stricture of the left ureter, postoperative

Postoperative diagnosis: SAME

Procedure:

1. Cystoscopy of ileal conduit.
2. Exchange of left nephroureteral catheter.

5.

Anesthesia: Monitored anesthesia care.

Description of procedure: The patient is identified in the holding area, marked, taken to the operating room. Subsequently, she was given monitored anesthesia care. She was prepped and draped in the usual sterile fashion in the supine position. Next, using a flexible cystoscope, the ileal conduit was entered. Cystoscopy was performed, which showed the ureteroileal anastomosis on the left with a stent protruding from it. There were no calcifications seen on the stent. Thus, the cystoscope was removed from the ileal conduit and then a super stiff wire was advanced through the nephroureteral catheter, up into the kidney. Once it was up there, then the catheter was taken off of the wire and then a new 8-French x 28-centimeter, nephroureteral ureteral catheter was advanced fluoroscopically into the level of the kidney. Once this was done and its position was confirmed fluoroscopically, the wire was pulled. A good curl was there fluoroscopically in the kidney, as the wire was pulled. A good curl was seen in the bladder and then the distal end was protruding out from the ileal conduit. This was placed in the ostomy bag and the patient was taken in stable condition to the recovery room.

What are the CPT® and ICD-9-CM Codes reported for the CRNA?

CPT® Code: 00860-QS, QZ, P3

ICD-9-CM Code: 593.3

What is the time reported for this service?

73 minutes.

RATIONALE: CPT® code: Both a cystoscopy and exchange of ureteral stent via ileal-conduit were performed. The ureteral stent was more complex and carries a higher base value. The ureter is part of the urinary system. Look in the index for Anesthesia/urinary tract, and you are directed to 00860 *Anesthesia for extraperitoneal procedures in lower abdomen, including urinary tract; not otherwise specified*. Anesthesia modifier QZ indicates the CRNA was without medical direction. Modifier QS is reported to show MAC. The physical status was 3.

ICD-9-CM code: The diagnosis is a stricture of the left ureter, postoperative. Look in the ICD-9-CM Index to Diseases under Stricture/ureter (postoperative) and you are directed to 593.3. Verification in the Tabular List confirms code selection.

Time: The start time is 12:18. The end time is 13:31. This calculates to 73 minutes.