Anesthesia (Multiple Choice)

CPC® Study Group with Legacy Education

1. What is the anesthesia code for a complete removal of the penis, including removal of both the left and right inguinal and iliac lymph nodes?

    a. 00932
    b. 00934
    c. 00936
    d. 00938

2. What anesthesia code(s) are assigned for an obstetric patient who had neuraxial labor analgesia provided by the anesthesiologist when the delivery was expected to be a normal vaginal delivery but the obstetrician performed a cesarean delivery when the fetal heart rate dropped?

    a. 62322
    b. 01967
    c. 01968
    d. 01967, 01968

3. Anesthesia start time is reported as 7:14 am, and the surgery began at 7:26 am. The surgery finished at 8:18 am and the patient was turned over to PACU at 8:29 am, which was reported as the ending anesthesia time. What is the anesthesia time reported?

    a. 7:14 am to 8:18 am (64 minutes)
    b. 7:14 am to 8:29 am (75 minutes)
    c. 7:26 am to 8:18 am (52 minutes)
    d. 7:26 am to 8:29 am (63 minutes)

4. Code 00350 Anesthesia for procedures on major vessels of the neck; not otherwise specified has a base value of ten (10) units. The patient is physical status P3, which allows one (1) extra base unit. Anesthesia start time is reported as 11:02 am, and the surgery began at 11:14 am. The surgery finished at 12:34 pm and the patient was turned over to PACU at 12:47 pm, which was reported as the ending anesthesia time. Using fifteen-minute time increments and a conversion factor of $100, what is the correct anesthesia charge?

    a. $1,500.00
    b. $1,600.00
    c. $1,700.00
    d. $1,800.00

5. A 94-year-old Medicare patient is having surgery to remove his parotid gland with dissection and preservation of the facial nerve. The surgeon has requested the anesthesia department place an arterial line. Report the CPT® code(s) for anesthesia?

    a. 00300, 36620
    b. 00100, 36620, 99100
    c. 00100, 99100
    d. 00400

6. A 72-year-old patient is undergoing a corneal transplant. An anesthesiologist is personally performing monitored anesthesia care and lists the physical status as P2. What CPT® coding and modifier(s) are reported for anesthesia?

    a. 00144, 99100
    b. 00144-AA-P2, 99100
    c. 00144-AA-QS-P2, 99100
    d. 00144-QK-QS-P2, 99100

7. A 30-year-old patient had anesthesia for an extensive spinal procedure with instrumentation under general anesthesia. The anesthesiologist performed all required steps for medical direction while directing one CRNA. What modifier(s) and CPT® coding are reported for the anesthesiologist and CRNA services?

    a. 00670-AA
    b. 00670-QK and 00670-QX
    c. 00670-QK and 00670-QZ
    d. 00670-QY and 00670-QX

8. Mr. Johnson, age 82, who has been in poor health with diabetes and associated peripheral neuropathy, is having a fem-pop bypass. The anesthesiologist documents he has severe systemic disease. What coding is correct for anesthesia?

    a. 01260-AA-P2, 99100
    b. 01272-AA-P3
    c. 01272-AA-P2, 99100
    d. 01270-AA-P3, 99100

9. What ICD-10-CM coding is reported for a type 2 diabetic cataract in the left eye?

    a. E11.8
    b. E11.9, E11.39
    c. E11.36
    d. E11.39

10. What ICD-10-CM coding is reported for a reaction to anesthesia, initial encounter?

    a. T88.2XXA
    b. T88.4XXA
    c. T88.52XA
    d. T88.59XA

ANESTHESIA (FILL IN THE BLANKS)

CPC® STUDY GROUP WITH LEGACY EDUCATION

1. What is the anesthesia code for a complete removal of the penis, including removal of both the left and right inguinal and iliac lymph nodes?

   CPT®: _____

2. What anesthesia code(s) are assigned for an obstetric patient who had neuraxial labor analgesia provided by the anesthesiologist when the delivery was expected to be a normal vaginal delivery but the obstetrician performed a cesarean delivery when the fetal heart rate dropped?

   CPT®: _____, _____

3. Anesthesia start time is reported as 7:14 am, and the surgery began at 7:26 am. The surgery finished at 8:18 am and the patient was turned over to PACU at 8:29 am, which was reported as the ending anesthesia time. What is the anesthesia time reported?

   _____

4. Code 00350 Anesthesia for procedures on major vessels of the neck; not otherwise specified has a base value of ten (10) units. The patient is physical status P3, which allows one (1) extra base unit. Anesthesia start time is reported as 11:02 am, and the surgery began at 11:14 am. The surgery finished at 12:34 pm and the patient was turned over to PACU at 12:47 pm, which was reported as the ending anesthesia time. Using fifteen-minute time increments and a conversion factor of $100, what is the correct anesthesia charge?

   $_____

5. A 94-year-old Medicare patient is having surgery to remove his parotid gland with dissection and preservation of the facial nerve. The surgeon has requested the anesthesia department place an arterial line. Report the CPT® code(s) for anesthesia?

   CPT®: _____, _____, _____

6. A 72-year-old patient is undergoing a corneal transplant. An anesthesiologist is personally performing monitored anesthesia care and lists the physical status as P2. What CPT® coding and modifier(s) are reported for anesthesia?

   CPT®: _____, _____

7. A 30-year-old patient had anesthesia for an extensive spinal procedure with instrumentation under general anesthesia. The anesthesiologist performed all required steps for medical direction while directing one CRNA. What modifier(s) and CPT® coding are reported for the anesthesiologist and CRNA services?

   Anesthesiologist: _____

   CRNA: _____

8. Mr. Johnson, age 82, who has been in poor health with diabetes and associated peripheral neuropathy, is having a fem-pop bypass. The anesthesiologist documents he has severe systemic disease. What coding is correct for anesthesia?

   CPT®: _____, _____

9. What ICD-10-CM coding is reported for a type 2 diabetic cataract in the left eye?

   ICD-10-CM: _____

10. What ICD-10-CM coding is reported for a reaction to anesthesia, initial encounter?

    ICD-10-CM: _____

Answer Key

1. What is the anesthesia code for a complete removal of the penis, including removal of both the left and right inguinal and iliac lymph nodes?

    a. 00932
    b. 00934
    c. 00936
    d. 00938

    Rationale: In the CPT® Index look for Anesthesia/Penis, which directs you to code range 00932-00938. Review the codes in the numeric section to determine 00936 fully describes the procedure and it is the correct code.

2. What anesthesia code(s) are assigned for an obstetric patient who had neuraxial labor analgesia provided by the anesthesiologist when the delivery was expected to be a normal vaginal delivery but the obstetrician performed a cesarean delivery when the fetal heart rate dropped?

    a. 62322
    b. 01967
    c. 01968
    d. 01967, 01968

    Rationale: Look in the CPT® Index for Anesthesia/Neuraxial/Labor, which directs you to code range 01967-01969 and Anesthesia/Neuraxial/Cesarean Delivery 01968,01969. Review the codes in the numeric section to determine that codes 01967 and +01968 are the correct codes. Code 01967 describes the initial service without the cesarean delivery. Add-on code +01968 adds the cesarean delivery. Add-on codes must be coded in conjunction with the primary code and cannot be coded alone. The correct codes are 01967, +01968.

3. Anesthesia start time is reported as 7:14 am, and the surgery began at 7:26 am. The surgery finished at 8:18 am and the patient was turned over to PACU at 8:29 am, which was reported as the ending anesthesia time. What is the anesthesia time reported?

    a. 7:14 am to 8:18 am (64 minutes)
    b. 7:14 am to 8:29 am (75 minutes)
    c. 7:26 am to 8:18 am (52 minutes)
    d. 7:26 am to 8:29 am (63 minutes)

    Rationale: Per anesthesia guidelines in the CPT® code book under the subheading Time Reporting: Anesthesia time begins when the anesthesiologist begins to prepare the patient for anesthesia in the operating room (or an equivalent area) and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under postoperative supervision. Anesthesia start time (7:14) and anesthesia end time (8:29) calculates as 1 hour and 15 minutes or 75 minutes of total anesthesia time.

4. Code 00350 Anesthesia for procedures on major vessels of the neck; not otherwise specified has a base value of ten (10) units. The patient is physical status P3, which allows one (1) extra base unit. Anesthesia start time is reported as 11:02 am, and the surgery began at 11:14 am. The surgery finished at 12:34 pm and the patient was turned over to PACU at 12:47 pm, which was reported as the ending anesthesia time. Using fifteen-minute time increments and a conversion factor of $100, what is the correct anesthesia charge?

    a. $1,500.00
    b. $1,600.00
    c. $1,700.00
    d. $1,800.00

    Rationale: Determining the base value is the first step in calculating anesthesia charges and payment expected. Time reporting is the second step. Per anesthesia guidelines in the CPT® code book under the subheading Time Reporting: Anesthesia time begins when the anesthesiologist begins to prepare the patient for anesthesia in the operating room (or an equivalent area) and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under postoperative supervision. In the scenario above, base units equal ten (10) plus one (1) physical status modifier unit (Base 10 + PS 1 = 11 units). Seven (7) time units, in fifteen-minute increments, is calculated by taking the anesthesia start time (11:02) and the anesthesia end time (12:47) and determining 1 hour 45 minutes or 105 minutes of total anesthesia time (105/15 = 7). Eighteen units (11 + 7 = 18) are then multiplied by the $100 conversion factor (18 X $100 = $1,800.00). Note: Base unit values are not separately listed in CPT®. The American Society of Anesthesiologists (ASA) determines the base unit value for anesthesia codes.

5. A 94-year-old Medicare patient is having surgery to remove his parotid gland with dissection and preservation of the facial nerve. The surgeon has requested the anesthesia department place an arterial line. Report the CPT® code(s) for anesthesia?

    a. 00300, 36620
    b. 00100, 36620, 99100
    c. 00100, 99100
    d. 00400

    Rationale: In the CPT® Index look for Anesthesia/Salivary Glands which directs you to code 00100. Reference the code in the numeric section to confirm that 00100 is the correct code. Hint - Coders may need to use the Surgery Section to determine that the parotid gland is included in the salivary glands. The arterial line placement is NOT included in the base value and may be reported separately with code 36620. In the CPT® Index look for Catheterization/Arterial System/Percutaneous. Due to patient's advanced age of 94, qualifying circumstance add-on code +99100 is also reported. The patient's age implies he is on Medicare; however, never assume a patient is a Medicare beneficiary. The documentation must support Medicare status. Do not report qualifying cirumstances for Medicare patients. Physical status is documented; however, additional units are not paid by Medicare.

6. A 72-year-old patient is undergoing a corneal transplant. An anesthesiologist is personally performing monitored anesthesia care and lists the physical status as P2. What CPT® coding and modifier(s) are reported for anesthesia?

    a. 00144, 99100
    b. 00144-AA-P2, 99100
    c. 00144-AA-QS-P2, 99100
    d. 00144-QK-QS-P2, 99100

    Rationale: Look in the CPT® Index for Anesthesia/Corneal Transplant referring you to 00144. Verify in the numeric section. In the HCPCS Level II code book locate the HCPCS Level II modifiers (Appendix B for AAPC HCPCS Level II). An anesthesiologist who is personally performing services reports the service with modifier AA and when the service performed is Monitored Anesthesia Care (MAC) modifier QS is also reported. The modifiers are sequenced first by the anesthesia provider then the MAC modifier, followed by the physical status modifier, which are attached to the appropriate anesthesia code. The qualifying circumstances add-on code +99100 is assigned for extreme age of the patient being older than 70 years of age. Never assume that the patient is a Medicare beneficiary because of age. The documentation must state that the patient is a Medicare beneficiary. When coding for Medicare, physical status modifier units are not paid. Do not report qualifying circumstances for Medicare.

7. A 30-year-old patient had anesthesia for an extensive spinal procedure with instrumentation under general anesthesia. The anesthesiologist performed all required steps for medical direction while directing one CRNA. What modifier(s) and CPT® coding are reported for the anesthesiologist and CRNA services?

    a. 00670-AA
    b. 00670-QK and 00670-QX
    c. 00670-QK and 00670-QZ
    d. 00670-QY and 00670-QX

    Rationale: In the CPT® Index look for Anesthesia/Spinal Instrumentation, which directs you to code 00670. Review code in the numeric section. An anesthesiologist who is medically directing care reports services separately from the CRNA, and denotes the number of concurrent cases with the appropriate modifier. Because there was only one case, the appropriate modifiers to report are QY for the physician and QX for the CRNA. A QZ modifier indicates the case was performed by a non-medically directed CRNA. Refer to your HCPCS Level II code book to verify these anesthesia modifiers.

8. Mr. Johnson, age 82, who has been in poor health with diabetes and associated peripheral neuropathy, is having a fem-pop bypass. The anesthesiologist documents he has severe systemic disease. What coding is correct for anesthesia?

    a. 01260-AA-P2, 99100
    b. 01272-AA-P3
    c. 01272-AA-P2, 99100
    d. 01270-AA-P3, 99100

    Rationale: Fem-pop bypass is an abbreviation for femoral-popliteal bypass of arteries in the upper leg. Look in the CPT® Index for Anesthesia/Bypass Graft/Leg, Upper which directs you to code 01270. Review the code in the numeric section to determine the correct code is 01270. The qualifying circumstance code +99100 is added to indicate the extreme age of the patient. Modifier AA is added to indicate the anesthesia is personally performed by the anesthesiologist. Physical status modifier P3 indicates the patient has severe systemic disease. There is no mention of Medicare; therefore, +99100 is reported.

9. What ICD-10-CM coding is reported for a type 2 diabetic cataract in the left eye?

    a. E11.8
    b. E11.9, E11.39
    c. E11.36
    d. E11.39

    Rationale: Look in the ICD-10-CM Alphabetic Index for Diabetes, diabetic/type 2/with/cataract, which directs you to code E11.36. Verify code selection in the Tabular List. Note that this is a combination code that defines the disease and complication with one code.

10. What ICD-10-CM coding is reported for a reaction to anesthesia, initial encounter?

    a. T88.2XXA
    b. T88.4XXA
    c. T88.52XA
    d. T88.59XA

    Rationale: Look in the ICD-10-CM Alphabetic Index for Anesthesia, anesthetic/complication or reaction NEC (see also Complications, anesthesia) which directs you to code T88.59-. The Tabular List indicates that code T88.59- requires a 7th character with no 6th character listing. Insert the placeholder X as the 6th character. Select the 7th character A for initial encounter.