

# **LCD for Monitored Anesthesia Care (MAC) for Certain Interventional Pain Management Services (L30570)**

## **Contractor Information**

### **Contractor Name**

First Coast Service Options, Inc.

### **Contractor Number**

09102

### **Contractor Type**

MAC - Part B

## **LCD Information**

### **LCD ID Number**

L30570

### **LCD Title**

Monitored Anesthesia Care (MAC) for Certain Interventional Pain Management Services

### **Contractor's Determination Number**

01991

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### **CMS National Coverage Policy**

Language quoted from CMS National Coverage Determination (NCDs) and coverage provisions in interpretive manuals are italicized throughout the Local Coverage Determination (LCD). NCDs and coverage provisions in interpretive manuals are not subject to the LCD Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See §1869(f)(1)(A)(i) of the Social Security Act.

Unless otherwise specified, *italicized* text represent quotation from one or more of the following CMS sources:

CMS Manual System Pub 100-02, Chapter 12, Section 50.I

### **Primary Geographic Jurisdiction**

Florida

## **Oversight Region**

Region IV

## **Original Determination Effective Date**

For services performed on or after 01/25/2010

## **Original Determination Ending Date**

## **Revision Effective Date**

## **Revision Ending Date**

## **Indications and Limitations of Coverage and/or Medical Necessity**

Monitored anesthesia care (MAC) is a specific anesthetic service for a diagnostic or therapeutic procedure. This LCD specifically addresses the use of MAC with certain interventional pain management procedures (CPT codes 20550, 20551, 20552, 20553, 27096, 62310, 62311, 64479, 64480, 64483, 64484, 64490, 64491, 64492, 64493, 64494 and 64495) where current practice supports that local anesthesia alone, inclusive of these procedures, is typical. For certain patients, the addition of mild sedation (physician service not separately payable) or moderate (conscious) sedation (CPT codes 99143-99150), may be part of these minimally invasive procedures. As outlined in this LCD, the addition of MAC, a second physician service (or other qualified anesthesia provider service), to the episode of care for these services must meet, but not exceed, the patient's medical need and be furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition.

MAC results in two physician services and is not usually medically necessary for interventional pain management procedures addressed in this LCD. MAC may be considered medically necessary, based on the nature of the procedure, the patient's clinical condition and/or the potential need to convert the patient from MAC to a general or regional anesthetic. MAC includes all aspects of general anesthesia care (pre-procedure through post-procedure), which includes:

- Pre-procedure/pre-anesthetic visit/exam (includes but is not limited to the patient's medical history, information related to present illness, social history, allergies, review of systems as applicable and a physical examination)
- Prescription of the anesthesia care required
- Administration of any necessary oral or parental medications (e.g., atropine, Demerol, valium)
- Post-operative anesthesia care

During MAC, the anesthesiologist or qualified anesthesia provider renders a number of specific services including but not limited to the following:

- Support of vital functions. Monitoring of vital signs, maintenance of the patient's airway and continual evaluation of vital functions in the anticipation of the need for the administration of general anesthesia or of the development of adverse physiological patient reaction to the procedure.
- Diagnosis and treatment of clinical problems that occur during the procedure.
- Administration of sedatives, analgesics, hypnotics, anesthetic agents or other medications as necessary for patient safety.
- Psychological support and physical comfort.
- Provision of other medical services as needed to complete the procedure safely.

*Medicare pays for reasonable and necessary MAC services on the same basis as other anesthesia services. Anesthesiologists use modifier QS to report monitored anesthesia care cases. Monitored anesthesia care involves the intraoperative monitoring by a physician or qualified individual under the medical direction of a physician or of the patient's vital physiological signs in anticipation of the need for administration of general anesthesia or of the development of adverse physiological patient reaction to the surgical procedure.*

Monitored anesthesia care often includes the administration of doses of medications for which the loss of normal protective reflexes or loss of consciousness is likely. If the patient is rendered unconscious and/or loses normal protective reflexes, the anesthesia care is considered a general anesthetic.

## **Indications**

Medicare will consider monitored anesthesia care medically reasonable and necessary when the patient's condition requires the presence of a second physician represented by an anesthesiologist or qualified anesthesia provider in addition to the provider performing the procedure. The patient's medical condition or nature of the procedure must require the presence of a second physician represented by an anesthesiologist or qualified anesthesia provider to administer the sedation if utilized, to manage the airway & vital signs, and to continually assess the patient for clinical problems and treat appropriately to ensure patient safety and comfort. The presence of an underlying condition alone or a stable treatable condition is not sufficient evidence that monitored anesthesia care is medically reasonable and necessary.

Monitored anesthesia care for interventional pain management services will be considered medically reasonable and necessary when the following criteria are met:

- Co-morbidities that would require the services of an anesthesiologist or qualified anesthesia provider such as pulmonary disease, cardiac disease, and/or psychiatric conditions with accompanying active symptoms necessitating close monitoring during the procedure, morbid obesity, severe sleep apnea, inability to follow simple commands (i.e., cognitive dysfunction with the inability to perform ADLs and provide self care, dementia or developmental delay), spasticity disorders that would make it difficult for the patient to lie still on the table, or any other co-morbidities that would support the need for the constant presence of an anesthesiologist or qualified anesthesia provider ( ASA 3 or ASA 4),
- Severe patient anxiety immediately prior to a procedure which may affect patient safety and comfort.
- Anticipated complexity to the planned standard procedures.
- Complications arising during the planned procedure or the inability to complete attempted interventional pain procedure in a patient who has received sufficient amounts of medications to induce minimal sedation.
- Medicare eligible pediatric patients.

## Limitations

Monitored anesthesia care performed solely based on the anesthetic being utilized or the patient's age, except as indicated above, is not considered medically reasonable and necessary.

Based on published peer reviewed literature and published guidelines, the performance of MAC is not considered the standard of care for interventional pain management services addressed in this LCD.

## Coding Information

### Bill Type Codes:

**Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.**

999x	Not Applicable
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### Revenue Codes:

**Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.**

99999	Not Applicable
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### CPT/HCPCS Codes

01991	ANESTHESIA FOR DIAGNOSTIC OR THERAPEUTIC NERVE BLOCKS AND INJECTIONS (WHEN BLOCK OR INJECTION IS PERFORMED BY A DIFFERENT PROVIDER); OTHER THAN THE PRONE POSITION
01992	ANESTHESIA FOR DIAGNOSTIC OR THERAPEUTIC NERVE BLOCKS AND INJECTIONS (WHEN BLOCK OR INJECTION IS PERFORMED BY A DIFFERENT PROVIDER); PRONE POSITION

## **ICD-9 Codes that Support Medical Necessity**

XX000

Not Applicable

## **Diagnoses that Support Medical Necessity**

N/A

## **ICD-9 Codes that DO NOT Support Medical Necessity**

XX000

Not Applicable

## **ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation**

## **Diagnoses that DO NOT Support Medical Necessity**

N/A

## **General Information**

### **Documentation Requirements**

Medical record documentation must support the medical necessity of monitored anesthesia services and the number of minutes billed. In addition, all components of the anesthesia care including pre-anesthetic examination and evaluation, peri-anesthesia care, and post-anesthesia care must be documented in the patient's medical record. This information is usually found in the hospital/office progress notes and anesthesia record. The following components must be included in the medical record:

- Pre-anesthesia evaluation – patient interview to include medical history, anesthesia history, medication history; appropriate physical exam; review of objective diagnostic data (e.g., laboratory, electrocardiogram, x-ray, etc.); assignment of physical status modifiers P3 or P4 (e.g., American Society of Anesthesiology physical status protocols); and formulation and discussion of an anesthesia plan with the patient and/or responsible adult and patient's attending physician.
- Peri-anesthesia (time based record of events) – immediate review prior to initiation of anesthetic procedure to include patient re-evaluation and check of equipment; monitoring of patient to include oxygenation, ventilation, circulation, and temperature by qualified anesthesia personnel that is present in the room throughout the MAC; types, amounts and times of all drugs and agents with technique used including intravenous fluids and/or blood products; any unusual events during the monitoring period; and status of patient at conclusion of anesthesia and procedure.
- Post-anesthesia – patient evaluation on admission and discharge from post-anesthesia; time-based record of vital signs and level of consciousness; types, amounts, and times of all drugs and agents administered; any unusual events including post-anesthesia or post-procedural complications; and post-anesthesia visits and any follow-up prescribed.

- The interventional pain physician must document in the medical record why the patient's clinical condition required MAC for the specific procedure performed.

## Appendices

### Utilization Guidelines

Interventional pain management procedures addressed in this LCD, generally do not require the addition of the physician services of MAC. Therefore, when MAC is utilized, the medical record must clearly support the medical reasonability and necessity describing why the patient's condition requires the presence of a second physician or qualified anesthesia personnel to perform monitored anesthesia care in addition to the physician performing the procedure. This situation must be clearly outlined and documented in the patient's medical record.

The presence of an underlying condition alone, as reported by ICD-9 CM codes, is not sufficient evidence that MAC is medically reasonable and necessary. The patient's medical condition must be significant enough to impact the need to provide MAC (such as the patient being on medication or being symptomatic, etc). The presence of a stable, treated condition is not generally sufficient medical justification for MAC.

**When the patient's condition does not meet medical necessity as outlined in the indications and limitations of this LCD, the provider must append the GA or GZ modifiers, as appropriate, along with the QS modifier. This will result in the appropriate denial of the services for the interventional pain management services as outlined above. MAC claims with the required QS modifier without the GA/GZ modifier should only be billed when MAC clearly meets the reasonable and necessary criteria for interventional pain injection procedures outlined in this LCD.**

### Sources of Information and Basis for Decision

American Society of Anesthesiologist, Distinguishing Monitored Anesthesia Care ("MAC") from Moderate Sedation/Analgesia (Conscious Sedation). Approved by the ASA House of Delegates on October 27, 2004 and last updated on September 8, 2008.

American Society of Anesthesiologist, Guidelines for Office-Based Anesthesia. Approved by the ASA House of Delegates on October 13, 1999 and last affirmed on October 27, 2004.

American Society of Anesthesiologist Position on Monitored Anesthesia Care. Approved by the House of Delegates on October 21, 1986, amended on October 25, 2005 and last updated on September 2, 2008.

CareCore Pain Management. Pain Management Criteria 2009. Accessed via the web at [www.carecore.com](http://www.carecore.com)

Highmark Medicare Services, Inc, L27489 Local Coverage Determination for Monitored Anesthesia Care (MAC).

Trailblazer Health Enterprises, LLC, L 26520 Local Coverage Determination for Monitored Anesthesia Care (MAC).

### Advisory Committee Meeting Notes

This Local Coverage Determination (LCD) does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this LCD was developed in cooperation with advisory groups, which includes representatives from numerous societies.

Florida Contractor Advisory Committee meeting held on October 10, 2009

Puerto Rico and U.S. Virgin Islands Contractor Advisory Committee meeting held on October 22, 2009

**Start Date of Comment Period**

09/24/2009

**End Date of Comment Period**

11/07/2009

**Start Date of Notice Period**

12/11/2009

**Revision History Number**

Original

**Revision History Explanation**

Revision Number:Original  
Start Date of Comment Period:09/24/2009  
Start Date of Notice Period:12/11/2009  
Original Effective Date:01/25/2010

LCR B2009-115  
December 2009 Update

**Reason for Change**

**Last Reviewed On Date**

**Related Documents**

This LCD has no Related Documents.

**LCD Attachments**

Coding Guidelines (HTM - 17,418 bytes)  
Comment Summary (09/24/2009-11/07/2009) (a comment and response document) (HTM - 40,541 bytes)

**All Versions**

Updated on 12/04/2009 with effective dates 01/25/2010 - N/A