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Coding and Billing for Labor Epidurals

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There are several unique aspects to proper coding and billing of obstetric anesthesia services. It is important that these are well understood so a practice can be sure it is making smart decisions and is submitting accurate claims for this anesthesia care. This Timely Topic will cover two of these aspects: determining time of neuraxial labor anesthesia services and proper use of the add-on codes that are part of the obstetric anesthesia code family.

Time for Neuraxial Labor Anesthesia

The ASA Relative Value Guide ® (RVG™) includes a special section on obstetric anesthesia within the Anesthesia Guidelines. The RVG states,

> *"Unlike operative anesthesia services, there is no single, widely accepted method of accounting for time for neuraxial labor anesthesia services.*
>
> *Professional charges and payment policies should reasonably reflect the costs of providing labor anesthesia services as well as the intensity and time involved in performing and monitoring any neuraxial labor anesthesia service."*

The section continues by offering four methods that are consistent with these principles. These methods are:

1. Base units plus time reported in minutes (insertion through delivery), subject to a **reasonable cap.** Delivery may include related services such as delivery of placenta or episiotomy/laceration repair.
2. Base units plus one unit per hour (time unit as defined by local standards and time reported in minutes) for neuraxial anesthesia service management plus direct patient contact time (insertion, management of adverse events, delivery, removal)
3. Incremental time-based fees (e.g. 0<2 hrs, 2-6 hrs, >6 hrs
4. Single fee.

An anesthesia group will need to consider and evaluate certain variables when determining the method that will work best for its practice. Variables that play a role in that decision may include but are not limited to:

- Availability of anesthesia personnel to manage labor analgesia after placement of the catheter;
- Level/Frequency of interaction with the patient by anesthesia personnel during labor course;
- Documentation requirements ; and
- Any specific requirements from the hospital or local payers.

Documentation should include all relevant clinical information. There may also be documentation requirements that are contingent upon the method used to determine fees. For example, documentation expectations for methods 1 and 3 are relatively straightforward; beyond a procedure note, documentation

should include a pre-operative note, anesthesia start and stop time to capture the time-based total or incremental charge, and a post-operative note.

Method 4, single flat fee, may only require the documentation of a procedure note as continued incremental or time-based documentation on the labor epidural record does not impact payment under this arrangement.

Method 2, which is similar to method 1 with the additional requirement to document any active interaction with the patient and management of epidural analgesia. The use of direct patient contact time does introduce some variability to the amount billed for the management of a labor epidural, however, appropriate documentation ensures and validates the additional effort required of the anesthesia professional.

As noted above, a practice may need to consider specific payer requirements. As an example, there is a good deal of variation among different states' Medicaid program requirements.

Add-on Codes

CPT® codes that describe obstetric anesthesia care include two add-on codes. Add-on codes are not reported as stand-alone services but are always reported in conjunction with another service. The two OB anesthesia add on codes are

01968 – *Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia*

01969 – *Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia*

These codes are to be reported in conjunction with code 01967 – *Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)*

While time for care as described with code 01967 is determined as explained above, time for anesthesia care reported with 01968 or 01969 is determined as it would be for any other anesthesia service requiring continuous face-to-face time with the patient.

For more information on OB anesthesia coding, please refer to the ASA RVG and CROSSWALK®

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