Summary

This policy describes reimbursement for anesthesia services. Anesthesia is the administration of a drug or anesthetic agent by an anesthesiologist in order for a patient to obtain muscular relaxation and partial or total loss of sensation and/or consciousness.

Policy Statement

This policy has been developed using guidelines from the American Society of Anesthesiologists (ASA), the American Medical Association (AMA), and the Centers for Medicare and Medicaid Services (CMS).

As defined by the American Medical Association, “The reporting of anesthesia services is appropriate by or under the responsible supervision of a physician. These services may include but are not limited to general, regional, supplementation of local anesthesia, or other supportive services in order to afford the patient the anesthesia care deemed optimal by the anesthesiologist during any procedure. These services include the preoperative and postoperative visits, the anesthesia care during the procedure, the administration of fluids and/or blood and the usual monitoring services.”

Anesthesia services must be reported using the appropriate code from the anesthesia section of the Current Procedural Terminology (CPT®) book (00100-01999). **Base Units:** The ASA assigns each anesthesia code (00100-01999) a base unit value which is used to establish a fee schedule. Base unit only codes and procedure codes without a base unit value assigned by ASA will be reimbursed at the standard clinic fee maximum, which is based on RBRVS (Resource Based Relative Value System). Intra-arterial and central venous are not included.

Procedures identified in the ASA Relative Value Guide as base unit only codes (that is, “+TM” is not indicated for the basic unit value) should be submitted with one unit except in situations when multiple procedural units are appropriate.

**Time Units:**
Anesthesia time starts when the anesthesiologist begins preparation for the induction of anesthesia in the operating room or equivalent area, and ends when the anesthesiologist is no longer providing anesthesia services. Time for anesthesia services is to be reported as 1 unit for each minute of anesthesia performed.

Anesthesia procedures that are reported in 900 minute units or more may be subject to requests for additional information in order to verify accuracy of
claims data submitted.

Time units are appropriate only for those procedures that are designated as “+ TM” in the ASA Relative Value Guide. Anesthesia claims should be submitted with time units only, when appropriate. Base units and/or modifying units should not be included in the number of units submitted by the provider.

Although reported in one-minute increments, the minutes are divided by 15 and always rounded up to the nearest whole number by Medica. This is the number used for ”Time Units” in the below reimbursement formula.

**Reimbursement Formula:**
Anesthesia reimbursement is calculated according to the following formula, for codes that are appropriate to be billed with time units:

\[
\text{Reimbursement} = (\text{Base Units} + \text{Time Units} + \text{Modifying Units}) \times \text{Conversion Factor} \times \text{Modifier Percentage}
\]

**Reporting other Services:**
When providing a medical or surgical procedure, physicians must report the appropriate CPT code 10021-99499, Category III code, or HCPCS code. These services should be submitted without anesthesia modifiers; with the exclusion of Qualifying Circumstance codes 99100-99140.

**Multiple Surgical Procedures:**
When multiple surgical procedures are performed during a single anesthetic administration, only the anesthesia code for the procedure with the highest Base Unit Value should be submitted for the anesthesia service, with time units to include the entire surgical session.

Multiple procedure reductions for multiple non anesthesia procedures will apply only to RBRVS codes. Reduction guidelines will follow Medica’s Multiple Procedure Policy.

**Evaluation and Management Services (E/M):**
Evaluation and Management (E/M) services (99201-99255, 99304-99499) are included in the normal preoperative and postoperative services for the anesthesia procedure. Note: The preoperative and postoperative time period is defined as the same day as an anesthesia procedure.

**Unbundled Services:**
Certain CPT codes are considered to be an integral part of the anesthesia service and are not separately reimbursable. Medica’s Unbundled Services Code List is
based on the CMS National Correct Coding Initiative.

**Anesthesia Modifiers:**
An appropriate anesthesia modifier is required for all anesthesia codes to indicate whether the anesthesia was personally performed, medically directed, or medically supervised. Required anesthesia modifiers are AA, AD, QK, QX, QY, and QZ. If one of these modifiers is not present, the claim will be denied.

<table>
<thead>
<tr>
<th>Mod</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA</td>
<td>Anesthesia performed personally by anesthesiologist</td>
</tr>
<tr>
<td>AD</td>
<td>Medical supervision by a physician; more than four concurrent anesthesia procedures</td>
</tr>
<tr>
<td>QK</td>
<td>Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals</td>
</tr>
<tr>
<td>QY</td>
<td>Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist</td>
</tr>
<tr>
<td>QX</td>
<td>CRNA service; with medical direction by a physician</td>
</tr>
<tr>
<td>QZ</td>
<td>CRNA service; without medical direction by a physician</td>
</tr>
</tbody>
</table>

When an anesthesiologist is not personally performing the anesthesia service but is directing one to four CRNAs or student nurse anesthetists, the modifier QK or QY should be used by the anesthesiologist. The corresponding CRNA claim should include a QX modifier.

Medical direction of qualified persons by the anesthesiologist will be covered only if the anesthesiologist:
- performs a pre-anesthesia examination and evaluation
- prescribes the anesthesia plan
- personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence
- ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist
- monitors the course of anesthesia administration at frequent intervals
- remains physically present and available for immediate diagnosis and treatment of emergencies
- provides indicated post-anesthesia care

CRNAs may not bill for multiple patients at the same time (e.g., a CRNA handles a large number of short procedures from 8:00 am - 12:00 noon, and attempts to bill for more than 4 hours of time). CRNA total time units reported must never exceed the amount of clock time from beginning to end of the service.

An anesthesia modifier is not required for base unit only codes or procedure codes without a base unit value assigned by ASA.

**Qualifying Circumstances Codes:**
Codes for qualifying circumstances may be used to indicate that the anesthesia was provided under a particularly difficult circumstance. The codes may be submitted in addition to the code for the anesthesia service. These codes have a base unit of one (1); time units do not apply. An anesthesia modifier (AA, AD, QK, QX, QY, or QZ) must be appended to all Qualifying Circumstances codes. Medica does not separately reimburse codes 99116 and 99135 as they are considered bundled into payment for other services.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99100</td>
<td>Anesthesia for patient of extreme age, under one year and over 70</td>
</tr>
<tr>
<td>99116</td>
<td>Anesthesia complicated by utilization of total body hypothermia</td>
</tr>
<tr>
<td>99135</td>
<td>Anesthesia complicated by utilization of controlled hypotension</td>
</tr>
<tr>
<td>99140</td>
<td>Anesthesia complicated by emergency conditions (specify)</td>
</tr>
</tbody>
</table>

**Physical Status Modifiers (P1-P6):**
Modifying units are designated by the use of Physical Status Modifiers, P1-P6. These allow for additional reimbursement for anesthesia on patients with critical physical status. The Physical Status Modifiers P3, P4, or P5 should be submitted on the claim in the second modifier position in addition to the required anesthesia modifier.

These modifiers are appropriate for use with the anesthesia service code only; they should not be appended to base unit only codes or procedural codes.

The unit value for these modifiers will be reimbursed as indicated below, as listed in the ASA Relative Value Guide. The provider should bill for time units only.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Definition</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>Normal healthy patient.</td>
<td>No additional units</td>
</tr>
<tr>
<td>P2</td>
<td>Patient with mild systemic disease</td>
<td>No additional units</td>
</tr>
<tr>
<td>P3</td>
<td>Patient with severe systemic disease</td>
<td>15 additional units</td>
</tr>
<tr>
<td>P4</td>
<td>Patient with severe systemic disease that is a constant threat to life</td>
<td>30 additional units</td>
</tr>
<tr>
<td>P5</td>
<td>Moribund patient who is not expected to survive without the operation</td>
<td>45 additional units</td>
</tr>
<tr>
<td>P6</td>
<td>Declared brain-dead patient whose organs are being removed for donor purposes</td>
<td>No additional units</td>
</tr>
</tbody>
</table>

**Monitored Anesthesia Care:**
According to the ASA, monitored anesthesia care (MAC) is a planned procedure in which an anesthesiologist provides the patient with local anesthesia, as well as, sedation and analgesia. There are three specific modifiers that should be used when providing monitored anesthesia care (QA, G8, and G9).
<table>
<thead>
<tr>
<th>Modifier</th>
<th>Definition</th>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>QS</td>
<td>Monitored anesthesia care service.</td>
<td>No additional units</td>
</tr>
<tr>
<td>G8</td>
<td>Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure</td>
<td>No additional units</td>
</tr>
<tr>
<td>G9</td>
<td>Monitored anesthesia care for patient who has history of severe cardiopulmonary condition.</td>
<td>No additional units</td>
</tr>
</tbody>
</table>

The QS modifier is informational only and should not be appended in the first modifier position.

The G8 and G9 modifiers may be billed on anesthesia claims. These modifiers should not be billed alone, but should be billed in addition to the required anesthesia modifiers (AA, AD, QK, QX, QY, and QZ).

**Epidural Anesthesia for Labor and Delivery:**

- **Insertion only:** When a provider performs the injection and/or insertion of an epidural catheter for continuous analgesia, but does not participate in the on-going management and monitoring of the epidural analgesia for labor and delivery, the claim should be for the injection and/or insertion service only (codes 62311 and 62319). Anesthesia time units are not appropriate for 62311 or 62319, as they are base unit only codes.

- **Insertion and Management:** When a provider inserts the epidural catheter and participates in on-going management and monitoring of the patient’s epidural analgesia, the anesthesia code 01967 (for vaginal delivery) or 01967 and 01968 (for cesarean delivery) should be billed for the complete service, using the appropriate anesthesia modifier, with anesthesia time units for actual face-to-face time. It would not be appropriate to bill 62311 or 62319 for the insertion of the catheter, in addition to the epidural management code.

- **Management Only:** In many cases, a physician will insert the epidural catheter, but a CRNA is responsible for the on-going management and monitoring of the patient’s epidural analgesia. When this is the case, the CRNA should submit the anesthesia code (e.g., 01967) using the appropriate anesthesia modifier, with anesthesia time units for actual face-to-face time. The anesthesiologist should submit the insertion only service code, 62319.

**Epidural Anesthesia for a Surgical Procedure:**
The insertion and administration of an epidural by an anesthesia provider for anesthesia purposes for a surgical procedure should be billed in the same manner as if general anesthesia had been used for the surgery. Codes 62311 or 62319 should not be used. Instead, the appropriate anesthesia code should be used.
Epidural Anesthesia for Pain Management:
Epidural anesthesia or pain management involves obtaining regional anesthesia of the pelvic, abdominal, genital and/or other areas by the injection of a local anesthetic into the epidural space of the spinal column.

The insertion of an epidural catheter for pain management services by any qualified provider will be reimbursable with either code 62311 or 62319. Only one unit per procedure would be appropriate because they are base unit only codes and time units do not apply.

If an epidural catheter for post-operative pain management is inserted before or after a surgical procedure, separate reimbursement will be allowed. However, modifier 59 must be appended to the epidural insertion code to indicate that a distinct procedural service was performed. (Example: A thoracotomy is performed under general anesthesia. After the surgery is completed, an epidural catheter is placed for post-operative pain management. It would be appropriate to bill 62319-59 in addition to the anesthesia code for the surgery.)

Daily Management of Epidural, Code 01996:
Daily hospital management of epidural drug administration includes daily visits and removal of the epidural catheter. If follow-up management of an epidural catheter takes place in a setting other than the hospital, an E/M code should be used. Code 01996 is for inpatient use only. Daily management on the same date as the catheter insertion is considered to be included in the insertion of the catheter. For subsequent postoperative days, it is appropriate to bill code 01996 when management of epidural administration is performed. However, removal of the epidural catheter does not constitute epidural management according to AMA; thus, if the only service performed is removal of the catheter, code 01996 should not be billed. Code 01996 is not appropriate to use for services related to patient controlled analgesia (PCA).
## Codes for Epidural Anesthesia:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>01967</td>
<td>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)</td>
</tr>
<tr>
<td>01968</td>
<td>Cesarean delivery following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>01969</td>
<td>Cesarean hysterectomy following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>01991</td>
<td>Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider); other than the prone position.</td>
</tr>
<tr>
<td>01992</td>
<td>Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider); prone position.</td>
</tr>
<tr>
<td>01996</td>
<td>Daily management of epidural or subarachnoid drug administration</td>
</tr>
<tr>
<td>62311</td>
<td>Injection, single of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural; lumbar, sacral (caudal)</td>
</tr>
<tr>
<td>62319</td>
<td>Injection, continuous infusion or intermittent bolus of diagnostic or therapeutic substance(s) (including anesthetic antispasmodic, opioid, steroid, other solution) epidural; lumbar, sacral (caudal).</td>
</tr>
</tbody>
</table>

### Modifiers

**Modifier 23** – Unusual Anesthesia. (Note: Medica does not provide additional reimbursement for this modifier. The physical status modifiers describe the circumstances for which Medica will provide additional reimbursement for unusual circumstances.)

**Modifier 24** – Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period.

**Modifier 25** – Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service.

**Modifier 59** – Distinct Procedural Service.

**Modifier 78** – Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period.

**Modifier XE** – Separate encounter. A service that is distinct because it occurred during a separate encounter.

**Modifier XP** – Separate practitioner. A service that is distinct because it was performed by a different practitioner.
Modifier XS – Separate structure. A service that is distinct because it was performed on a separate organ/structure.

Modifier XU – Unusual non-overlapping service. The use of a service that is distinct because it does not overlap usual components of the main service.

Definitions

Add-On Codes – Some surgical CPT add-on codes are cross-walked to ASA codes. These codes should not be used alone, and are adjunct codes only. Anesthesia services should not be submitted with add-on codes, as these may have an inappropriate anesthesia base unit value compared to the actual primary surgical procedure code. Additional information about adjunct codes can be found in the Surgery Guidelines of the CPT manual under “Add-on Codes.”

Code Lists

Anesthesia RBRVS Code List 2016

Anesthesia Unbundled Services Code List 2016

Anesthesia Single Case Code List 2016

Resources

- American Society of Anesthesiologists Crosswalk Guide
- American Society of Anesthesiologists Relative Value Guide
- Centers for Medicare and Medicaid Services (CMS)
- CMS National Correct Coding Initiative (NCCI)
- Healthcare Common Procedure Coding System (HCPCS)

Effective Date

10/01/1998

Revision Updates

11/3/2016 Annual policy review
01/01/2016 Annual code update
01/01/2015 Annual code update; accepted new X modifiers; edits will be applied to the X modifiers effective February 14, 2015
12/11/2014 Annual policy review
01/01/2014 Annual code update

© 1998-2016 Medica. Medica® is a registered service mark of Medica Health Plans. “Medica” refers to the family of health plan businesses that includes Medica Health Plans, Medica Health Plans of Wisconsin, Medica Insurance Company, Medica Self-Insured, and Medica Health Management, LLC.