Reimbursement Policy	
Title: Anesthesia	
Policy Number: RP-P-115X	**Application:** All Medica Members
Last Reviewed: 11/15/2021	**Effective Date:** 10/01/1998
Related Policies: Add-On Code, Bundled Services, CCI Editing, Multiple Procedure Reduction	

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Summary:

This policy has been established to provide reimbursement guidelines 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 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 reimbursement. 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 (when "+TM" is not indicated for the basic unit value) should be submitted with one unit except in situations when multiple procedural units are appropriate.

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

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 service.

Time units are appropriate only for those procedures that are designated as "+ TM" in the ASA Relative Value Guide. Time for anesthesia service is to be reported as 1 unit for each minute of anesthesia performed. 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 anesthesia reimbursement formula. Anesthesia reimbursement is calculated according to the following formula, for codes that are appropriate to be reported with time units.

[Base Units + Time Units + Modifying Units] x Conversion Factor x Modifier Percentage

Note: Anesthesia services reported with 900 minute units or more may be subject to requests for additional information in order to verify accuracy of claims data submitted.

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 Reduction* reimbursement 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. 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.

MOD	Description	Reimbursement Percentage
AA	Anesthesia services performed personally by anesthesiologist	100%
AD	Medical supervision by a physician: more than four concurrent anesthesia procedures	100%
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals	50%
QX	CRNA service with medical direction by a physician	50%
QY	Medical direction of one certified nurse anesthetist (CRNA) by an anesthesiologist	50%
QZ	CRNA service: without medical direction by a physician	100%

When an anesthesiologist is not personally performing the anesthesia service but is directing one to four certified registered nurse anesthetists (CRNA), student nurse anesthetists or certified anesthesia assistants (CAA), the modifier QK or QY should be used by the anesthesiologist. The corresponding CRNA or CAA claim should be reported with 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 report anesthesia services 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 report 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.

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. Time units do not apply. An anesthesia modifier (AA, AD, QK, QX, QY, or QZ) must be appended to all Qualifying Circumstances. Medica does not separately reimburse codes 99116 and 99135 as they are considered bundled into payment for other services.

Note: Please see *Exclusions/Exemptions* section within policy for additional information pertaining to Medicaid and Medicare products.

Code	Description
99100	Anesthesia for patient of extreme age, younger than 1 year and older than 70 (List separately in addition to code for primary anesthesia procedure)
99116	Anesthesia complicated by utilization of total body hypothermia (List separately in addition to code for primary anesthesia procedure)
99135	Anesthesia complicated by utilization of controlled hypotension (List separately in addition to code for primary anesthesia procedure)
99140	Anesthesia complicated by emergency conditions (specify) (List separately in addition to code for primary anesthesia procedure)

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. These modifiers are appropriate for use with the anesthesia service code only. The modifiers 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 only report the modifiers for time unit anesthesia services only.

MOD	Description	Additional Units
P1	A normal health patient	0 units
P2	A patient with mild systemic disease	0 units
P3	A patient with severe systemic disease	1 units
P4	A patient with severe systemic disease that is a constant threat to life	2 units
P5	A moribund patient who is not expected to survive without the operation	3 units
P6	Declared brain-dead patient whose organs are being removed for donor purposes	0 units

Important: The Physical Status Modifiers P3, P4, or P5 need to be reported on the claim in the second modifier position in addition to the required anesthesia modifier.

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 anesthesia sedation and analgesia.

There are three specific modifiers that should be used when providing monitored anesthesia care (QS, G8, and G9).

MOD	Description	Additional Units
QS	Monitored anesthesia care service	0 units
G8	Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure	0 units
G9	Monitored anesthesia care for patient who has history of severe cardio-pulmonary condition	0 units

The QS modifier is informational only.

The G8 and G9 modifiers may be reported on anesthesia claims. These modifiers should not be reported alone, but 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 (62320 – 62327). Anesthesia time units are not appropriate for 62320 – 62327 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 reported 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 report 62320 – 62327 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 codes 62320 – 62327.

Code	Description
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)
+ 01968	Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed)
+ 01969	Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed)
01991	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different physician or other qualified health care professional); other than the prone position

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 reported in the same manner as if general anesthesia had been used for the surgery. Codes 62320 - 62327 should not be used. Instead, the appropriate anesthesia code should be used.

Epidural Anesthesia for Pain Management
Epidural anesthesia for pain management involves 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 (62320 – 62327). 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, the appropriate modifier 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 report 62325 with modifier 59 in addition to the anesthesia code for the surgery.

Code	Description
62320	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance
62321	Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)
62322	Injection(s), of the diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance
62323	Injection(s), of the diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie fluoroscopy or CT)

Code	Description
62324	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance
62325	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)
62326	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance
62327	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie fluoroscopy or CT)

Daily Management of Epidural: CPT 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 report 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 reported. Code 01996 is not appropriate to use for services related to patient controlled analgesia (PCA).

Code	Description
01996	Daily hospital management of epidural or subarachnoid continuous drug administration

Exclusions/Exemptions:
• Medicaid Product: Payment for qualifying circumstances will only be made if the member is less than one year of age for over 70 years of age (99100). Report the anesthesia for a member of extreme age code on a separate line and report one unit of service. • Medicare Product: Qualifying circumstances codes are not eligible for separate reimbursement and considered to be a part of another service.

Code Lists:
Anesthesia RBRVS Code List
Anesthesia Unbundled Services Code List
Anesthesia Single Case Code List

Modifiers	Description
22	Increased procedural services
23	Unusual anesthesia
24	Unrelated evaluation and management service by the same physician or other qualified health care professional during a postoperative period
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
47	Anesthesia by surgeon
59	Distinct procedural service
76	Repeat procedure or service by the same physician or other qualified health care professional
77	Repeat procedure by another physician or other qualified health care professional
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
79	Unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period
XE	Separate encounter, a service that is distinct because it occurred during a separate encounter
XP	Separate practitioner, a service that is distinct because it was performed by a different practitioner
XS	Separate structure, a service that is distinct because it was performed on a separate organ/structure
XU	Unusual non-overlapping service, the use of a service unit that is distinct because it does not overlap usual components of the main service

Definitions:	
Add-On Code	A code which cannot be reported as a stand-alone code. A code always reported in addition to the primary service/procedure.
Stand-Alone Codes	A code which can be reported by itself, without the need for a primary service/procedure by the same physician or other qualified health care professional

Resources:
American Society of Anesthesiologists (ASA)
Centers for Medicare and Medicaid Services (CMS)
Current Procedural Terminology (CPT®)
Healthcare Common Procedure Coding System (HCPCS)
National Physician Fee Schedule (NPFS)

Effective Date:	10/01/1998

Revision Updates:	
2/10/2022	Code List Update
11/15/2021	Annual Policy Review Policy Enhancement Include Anesthesia Assistant
01/01/2020	Annual Policy Review
01/01/2019	Annual Code Review