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Anesthesia Services

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Description: Anesthesia services consist of the administration of an anesthetic agent, typically by injection or inhalation, causing partial or complete loss of sensation, with or without loss of consciousness.

These services are provided as one of the following types of anesthesia:

Regional – the use of local anesthetic agents to produce circumscribed areas of loss of sensation. Regional anesthesia can include nerve blocks, spinal, epidural, and field blocks. Epidural anesthesia is produced by injection of an anesthetic agent into the epidural space.

Local – infiltration or topical application of an anesthetic agent at or near the site where the procedure is to be performed, creating loss of sensation to the area.

General – loss of the ability to perceive pain, associated with loss of consciousness, produced by intravenous infusion of drugs or inhalation of anesthetic agents.

Monitored Anesthesia Care (MAC) – intraoperative monitoring by a physician or other qualified individual under the medical direction of the 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.

Moderate Sedation - moderate (conscious) sedation is defined by the American Society of Anesthesiologists (ASA) as a drug-induced depression of the consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain cardiovascular function or a patent airway, and spontaneous ventilation is adequate.

Reimbursement Information

Anesthesia services are eligible for coverage when:

- the procedure for which the anesthesia is administered is a covered service.
- the anesthesia is administered by a:
    - Physician (other than the operating physician, assistant surgeon, or obstetrician) qualified to administer general anesthesia or to appropriately supervise anesthesia, OR
    - Certified Registered Nurse Anesthetist (CRNA), OR
    - Anesthesiologist Assistant (AA)

Reporting Time Units

The period of time on which anesthesia time units are based begins when the anesthesiologist is first in attendance with the patient for the purpose of induction of anesthesia and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the patient, that is, when the patient may be placed safely under postoperative care. Time spent in the recovery room is included in the anesthesia base units and no additional reimbursement is provided.

Reimbursement Calculation

Anesthesia time should be submitted on the claim as total minutes. For example, 1 hour and 9 minutes of anesthesia time is billed as 69 minutes. The total minutes should be placed in field 24G of the CMS1500 claim form (or its electronic equivalent). FHCP then converts minutes into 15-minute increments. FHCP rounds the time units to the nearest tenth of a unit.

Reimbursement for Time Based Services with Anesthesia Modifiers

The following modifiers are utilized by the system to determine payment to the provider. One of these modifiers must be associated with the time-based anesthesia code in order for the line to be appropriately adjudicated.

Modifier	Adjustment
AA	100%
QZ	100%
QK	50%
QX	50%
QY	50%

Modifier	Base Units
P1	0
P2	0
P3	1
P4	2
P5	3
P6	0

Note: P modifiers are non-Medicare only.

Anesthesia Performed by Anesthesiologist or CRNA (AA, QZ Modifier):

(Base Unit + Total Time Units) X Anesthesia Conversion Factor = Allowance

(Base Unit + Additional Base Units for P Modifier + Total Time Units) X Anesthesia Conversion Unit = Allowance

Anesthesia Performed under Medical Direction (QK, QX and QY modifiers):

[(Base Unit + Total Time Units) X Anesthesia Conversion Factor] X Modifier Adjustment .50 = Allowance for each provider

[(Base Unit + Additional Base Units for P Modifier + Total Time Units) X Anesthesia Conversion Unit] X Modifier Adjustment .50 = Allowance for each provider

Inclusive Components of Anesthesia

The usual pre-operative and post-operative visits and consultations, the anesthesia care during the procedure, the administration of fluids and/or blood, and the usual monitoring services (e.g., ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry) are included in the reimbursement for the anesthesia service. Unusual forms of monitoring (e.g., intra-arterial, central venous, and Swan-Ganz) are not included and are reimbursed separately.

Pre-operative care, post-operative care, or consultations provided by the anesthesiologist for care other than normal or uncomplicated care (e.g., pain management), may be eligible for coverage if separately identifiable services were rendered. Substantiating documentation would be required to establish that the services were not part of normal pre-or post-operative care (e.g., physician history and physical, physician progress notes, physician operative notes).

The following procedures and services ae considered as integral components of general anesthesia and are not reimbursed separately. This is not an all-inclusive list. Additional services that are not separately reimbursed with anesthesia services are stated in the Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) Policy Manual, Chapter 2.

31500	Intubation, endotracheal, emergency procedure
31505	Laryngoscopy, indirect; diagnostic (separate procedure)
31515	Laryngoscopy direct; with or without tracheoscopy, for aspiration
31527	Laryngoscopy direct; with insertion of obturator
31622	Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; diagnostic, with or without cell washing (separate procedure)
36000	Introduction of needle or intracatheter, vein
36430	Transfusion, blood or blood components
92950	Cardiopulmonary resuscitation (e.g., in cardiac arrest)
92953	Temporary transcutaneous pacing
92960	Cardioversion, elective, electrical conversion of arrhythmia, external

93000-93010	Electrocardiogram, routine ECG with at least 12 leads
93040-93042	Rhythm ECG, one to three leads
93922-93924	Noninvasive study of either/both Lower extremity or upper extremity arteries
94002	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day
94640	Pressurized or non-pressurized inhalation treatment for acute airway obstruction or for sputum induction for diagnostic purposes (e.g., with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device)
94680-94690	Oxygen update, expired gas analysis
94760-94762	Noninvasive ear or pulse oximetry for oxygen saturation
95812-95822	Electroencephalogram (EEG)

Transesophageal Echocardiography

Transesophageal Echocardiography (TEE) placement and interpretation is not considered for separate reimbursement in addition to payment for the primary anesthesia procedure. However, when this service is performed for diagnostic purposes and documentation is provided to include a formal report, this service may be considered for separate reimbursement in accordance with CMS guidelines

Monitored Anesthesia Care

Monitored anesthesia care (identified by the -QS modifier) is eligible for coverage when performed by the anesthesiologist, CRNA or qualified anesthetist under the medical direction of a physician, and includes all of the following criteria:

- Requested by the attending physician/operating surgeon.
- Performance of a pre-anesthetic examination and evaluation.
- Prescription of the anesthesia care required.
- Administration of necessary oral and parenteral medications.
- Personal participation in, or medical direction of, the entire plan of care.
- Continuous physical presence of the anesthesiologist or, in the case of medical direction, of the qualified anesthetist (i.e., CRNA, AA) being medically directed (must be present in the operating suite during operative procedure) or proximate presence (within vicinity of the operating suite) or (in the case of medical direction) availability of the anesthesiologist for diagnosis or treatment of emergencies.
- Usual non-invasive cardiovascular and respiratory monitoring.
- Oxygen administration, when indicated.

- Intravenous administration of sedatives, tranquilizers, anti-emetics, narcotics, other analgesics, beta-blockers, vasopressors, bronchodilators, anti-hypertensives, or other pharmacologic therapy as may be required in the judgment of the anesthesiologist.

Reimbursement for monitored anesthesia care is limited to one provider (anesthetist or anesthesiologist) per day.

Non-covered Anesthesia Services

The following anesthesia services are **NOT** eligible for coverage:

- Anesthesia by hypnosis
- Anesthesia by acupuncture
- Anesthesia for non-medically necessary cosmetic surgery
- Standby, non-active participation for anesthesiology during surgery
- Anesthesia for investigational or non-covered surgical procedures

Positioning of the Patient

Positioning the patient (e.g., lithotomy, lateral, prone, sitting, field avoidance) before, during, or following a therapeutic procedure, is considered incidental to other services provided and is not reimbursed separately.

Qualifying Circumstances for Anesthesia

Reimbursement for Qualifying Circumstances for Anesthesia (99100-99140) is included in the basic allowance for other anesthesia procedures (00100-01999).

Local anesthesia

Local anesthesia is an integral part of the surgical procedure, and no additional reimbursement is provided.

Multiple Surgical Procedures

When multiple surgical procedures are performed, the base value of anesthesia is the base value for the procedure with the highest relative unit value. No reimbursement is provided for the base unit values of additional procedures. Time units cover the additional time required for these procedures.

Pre-anesthesia Evaluation

A pre-anesthesia evaluation by the anesthesiologist when surgery is canceled may be covered at the level of care rendered (e.g., brief or limited visit) as a hospital or office visit.

A pre-anesthesia evaluation by the anesthesiologist when the procedure is delayed is not eligible for coverage as a separate procedure. It is an integral part of the subsequent anesthesia services.

Anesthesia Administered by the Operating Surgeon

Reimbursement for general anesthesia or intravenous analgesia administered by the operating surgeon, assistant surgeon, or obstetrician is included in the basic allowance for the surgical procedure performed.

Ventilation Management

Ventilation Assist and Management is a covered service. This service is not necessarily confined to the critical care area. It can be rendered in a hospital setting, or in rare cases rendered in extended care facilities or the home setting. Reimbursement for initial ventilation and management is limited to one within a 30-day period. However, ventilation and management is incidental to the anesthesia service when it is performed on the same day as the anesthesia.

Epidurals

Epidural analgesia involves the administration of a narcotic drug through an epidural catheter. When performed as the primary type of anesthesia, the time required is included in the total anesthesia minutes reported.

A continuous epidural reported using procedure code 62319 is reimbursed only one time, as a flat rate code.

Daily hospital management of epidural or subarachnoid continuous drug administration (01996) is limited to one service per day on subsequent days. This code is reimbursed at a rate of three times the anesthesia conversion unit. There are no time units involved in the reimbursement calculation.

Labor Epidurals

Anesthesia for labor epidurals are time-based services and should be billed as total minutes.

01967: Vaginal delivery with epidural for pain management. Code may be reported as a single anesthesia service. Depending on the terms of the participating provider agreement, reimbursement may be based on base units plus time units (insertion through delivery) subject to a maximum time of 7 hours or 420 minutes.

01968: Cesarean delivery following failed attempt at vaginal delivery. This is an add-on code and should always be reported with 01967.

01969: Cesarean delivery followed by a cesarean hysterectomy after failed planned vaginal delivery. This is an add-on code and should always be reported with 01967.

Medical Direction

Medical direction of a qualified anesthetist (CRNA) by the anesthesiologist may be covered when the anesthesiologist

- remains physically present in the operating suite and available for immediate diagnosis and treatment of emergencies,
- does not personally administer an anesthetic to another patient while medically directing,
- directs not more than four (4) anesthetists performing concurrent procedures,

- performs a pre-anesthetic examination and evaluation,
- prescribes the anesthesia plan,
- personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence,
- ensures that procedures not performed by the anesthesiologist are performed by a qualified individual,
- monitors the course of anesthesia administration at frequent intervals, AND
- provides indicated post-anesthesia care.

NOTE: A physician who is concurrently directing the administration of anesthesia to 1-4 patients should not typically be involved in providing services to other patients except in the following situations:

- Addressing an emergency of short duration in the immediate area.
- Administering an epidural or caudal anesthetic to ease labor pain or periodic (rather than continuous) monitoring of an obstetrical patient.
- Receiving patients entering the operating suite for the next surgery.
- Checking or discharging patients in the recovery room.
- Handling scheduling matters.

If medical direction is reported by the anesthesiologist (modifier QY or QK), an anesthesia service for the same patient on the same day by a CRNA indicating no medical direction (modifier QZ) will be returned for corrected billing by the CRNA of the appropriate modifier.

Likewise, if medical direction is reported and received by a CRNA prior to the receipt of a service without medical direction, then a claim is received for an anesthesia service for the same patient on the same day by the anesthesiologist indicating medical direction, the claim for the medical direction will be returned pending proper modifier usage.

It would not be expected that a CRNA would report a modifier for medical direction.

Medical Supervision vs. Medical Direction

When the anesthesiologist does not fulfill all of the medical direction requirements listed above, the concurrent anesthesia services are considered medical supervision services and are not considered medical direction services. Reimbursement for medical supervision is included in the hospital ancillary services.

Moderate Sedation

Moderate Sedation Moderate (conscious) sedation, also known as conscious sedation, is defined as a drug induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain cardiovascular function or a patent airway, and spontaneous ventilation is adequate.

Codes 99151-99153 and 99155-99157 describe moderate sedation. Moderate sedation codes are not used to report administration of medications for pain control, minimal sedation (anxiolysis), deep sedation or monitored anesthesia care (00100-01999).

CMS created Healthcare Common Procedure Coding System (HCPCS) code G0500 to describe the initial 15 minutes of intraservice time provided by the same physician or other qualified health care professional performing a gastrointestinal endoscopic procedure that the sedation supports. Code G0500 should be used if the procedure the sedation supports is a gastrointestinal endoscopic procedure, and the same physician or other qualified health care professional provides the sedation. Code 99153 would be used to report additional time, beyond the initial 15 minutes of intraservice time, if appropriate.

Preservice, intraservice and postservice work activities are described in American Medical Association CPT® Professional Edition. These activities are included in the moderate sedation codes and are not reported separately.

Intraservice time is used to define the appropriate code(s) to report moderate sedation services and must be documented in the clinical records. Preservice and postservice work times are not used to select the appropriate code. Intraservice time begins with the administration of the sedation agent and ends when the procedure is completed, the patient is stable for recovery status and the physician or other qualified healthcare professional providing the sedation ends personal continuous face to face time with the patient.

When a second physician other than the health care professional performing the procedure provides the moderate sedation in a facility setting, codes 99155-99157 are appropriate; when these services are performed by the second physician in the non-facility setting (e.g., physician office, imaging center, clinic), codes 99155-99157 should not be reported and are not reimbursed.

Furthermore, codes 99151-99157 will not be separately reimbursed with any procedure whose description contains “with anesthesia”, “under anesthesia”, “under or requiring general anesthesia”, etc., based on their verbiage and the fact that conscious sedation is not expected with these procedures. CPT® 99153 has no physician work associated with it and is therefore a technical component only code (PC/TC indicator 3). When billed in a facility setting it is not payable to the physician but may be paid to the facility. When billed in the office it is payable to the physician.

BILLING/CODING INFORMATION:

The following CPT procedure codes may be used to describe anesthesia services:

CPT Coding:

00100 – 01999	Anesthesia (site specific)
99100	Anesthesia for patient of extreme age, under one year and over seventy (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)

NOTE: Qualifying Circumstances for Anesthesia is included in the basic allowance for anesthesia procedures.

The following codes may be used to describe moderate sedation:

99151	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient younger than 5 years of age
99152	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older
99153	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes intraservice time (List separately in addition to code for primary service)
99155	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient younger than 5 years of age
99156	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional Anesthesia Services – 10-003 Page 8 of 9 performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient age 5 years or older
99157	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intraservice time (List separately in addition to code for primary service)
G0500	Moderate sedation services provided by the same physician or other qualified health care professional performing a gastrointestinal endoscopic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient age

CPT Modifiers:

47	Anesthesia by surgeon
P1	A normal healthy patient
P2	A patient with mild systemic disease
P3	A patient with severe systemic disease
P4	A patient with several systemic disease that is a constant threat to life
P5	A moribund patient who is not expected to survive without the operation

P6	A declared brain-dead patient whose organs are being removed for donor purposes

HCPCS Modifiers:

AA	Anesthesia services performed personally by anesthesiologist
AD	MD supervision, more than 4 anesthesia services
G8	Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure
G9	Monitored anesthesia care for patient who has history of severe cardiopulmonary condition
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals
QS	Monitored anesthesia care service
QX	CRNA service; with medical direction by a physician
QY	Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist
QZ	CRNA service; without medical direction by a physician