**Anesthesia Coding Guidelines**

Anesthesia is the administration of a drug or gas to induce partial or complete loss of consciousness.

An anesthesiologist, Qualiﬁed Nonphysician Anesthetist or an Anesthesia Assistant (AA) can provide anesthesia services. The anesthesiologist and the Qualiﬁed Nonphysician Anesthetist can bill separately for anesthesia services they personally perform. In cases of medical direction, both the anesthesiologist and the Qualiﬁed Nonphysician Anesthetist would bill Medicare for their component of the procedure. Each provider should use the appropriate anesthesia modiﬁer.

Note: If the surgery is non-covered, the anesthesia is also non-covered. Anesthesia procedure codes are organized as follows:

**Modifiers**

In anesthesia every anesthesia procedure billed to Medicare must include one of the following anesthesia HCPCS modiﬁers:

***Anesthesiologist***

• AA: Anesthesia services performed personally by anesthesiologist or when an anesthetist assists a physician in the care of a single patient.

• QY: Medical direction of one Qualiﬁed Nonphysician

• QK: Medical direction of two, three or four concurrent anesthesia procedures involving qualiﬁed individuals.

• AD: Medical supervision by a physician: more than four concurrent anesthesia procedures.

***Qualiﬁed Nonphysician Anesthetist***

• QX: Qualiﬁed Nonphysician Anesthetist service: with medical direction by a physician.

• QZ: Qualiﬁed Nonphysician Anesthetist service: without medical direction by a physician.

***Monitored Anesthesia Care (MAC)***

**•** QS: Monitored Anesthesia Care services (can billed by a Qualiﬁed Nonphysician Anesthetist, AA or physician).

Two separate claims must be ﬁled for medically directed anesthesia procedures-one for the anesthesiologist and one for the Qualiﬁed Nonphysician Anesthetist. Medical direction can occur in several different scenarios. When billing for the anesthesia services, please refer to the following examples for appropriate modiﬁer usage:

Example #1: An anesthesiologist is medically directing one Qualiﬁed Nonphysician Anesthetist. The anesthesiologist should bill with the QY HCPCS modiﬁer and the Qualiﬁed Nonphysician Anesthetistshould bill with the QX HCPCS modiﬁer. The Medicare payment would be split equally between the two providers with each provider receiving 50 percent of the Medicare allowable amount for the procedure.

Example #2: An anesthesiologist is medically directing two, three or four Qualiﬁed Nonphysician Anesthetists. The anesthesiologist should bill with the QK HCPCS modiﬁer and the Qualiﬁ ed Nonphysician Anesthetistshould bill with the QX HCPCS modiﬁer. The Medicare payment would be split equally between the two providers with each provider receiving 50 percent of the Medicare allowable amount for the procedure.

If the medical direction requirements are not met, a Qualiﬁed Nonphysician Anesthetist may submit a claim with the QZ HCPCS modiﬁer indicating the service was without medical direction by a physician.

**Medical Supervision**

If an anesthesiologist is medically directing more than four Qualiﬁed Nonphysician Anesthetists, the Medicare regulations indicate that the service must be billed as medically supervised as opposed to medically directed anesthesia services. • The anesthesiologist should bill with the AD HCPCS modiﬁer and; • Qualiﬁed Nonphysician Anesthetist should bill with the QX HCPCS modiﬁer.

**Group Practice**

If anesthesiologists are in a group practice, one physician member may provide the pre-anesthesia examination and evaluation while another fulﬁlls the other criteria. Also, one physician member of the group may provide post-anesthesia care while another member of the group furnishes the other component parts of the anesthesia service. However, the medical record must indicate that the physicians furnished the services and identify the physicians who rendered them.

Example:

• The ﬁrst anesthesiologist or Qualiﬁed Nonphysician Anesthetist spent 15 minutes with the patient.

• The second anesthesiologist or Qualiﬁed Nonphysician Anesthetist spent 45 minutes with the patient.

• The claim would be submitted for the second anesthesiologist or Qualiﬁed Nonphysician Anesthetist with 60 minutes for the entire time period of the procedure.

**Qualiﬁed Nonphysician Anesthetist Billing**

All claims for anesthesia furnished by qualiﬁed anesthetists must indicate:

• The duration of the procedure in minutes – how much time elapsed from the preparation of the patient for induction to the moment when the anesthetist was no longer in attendance.

• Whether an anesthesiologist or other physician (except the surgeon) functioning as an anesthesiologist medically directed the anesthesia. Use the QX or QZ HCPCS modiﬁer to fulﬁll this requirement.

**Anesthesia time**

Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service. In counting anesthesia time, the anesthesia practitioner can add blocks of time around an interruption in anesthesia time as long as the anesthesia practitioner is furnishing continuous anesthesia care within the time periods around the interruption.

One time unit will be allowed for each 15-minute interval, or fraction thereof, starting from the time the physician begins to prepare the patient for induction and ending when the patient may safely be placed under post-operative supervision and the physician is no longer in personal attendance. Actual time units will be paid; do not round.

The 15-minute time interval will be divided into the total time indicated on the claim. Total time should always be accurately reported in minutes. Actual time units will be paid; no rounding will be done up to the next whole number – only round to the next tenth.

**CPT modiﬁer 76** – Repeat Procedure or Service by Same Physician The patient is returned to the operating room on the same day for the same or a related procedure. The same physician who is performing the repeat service should bill the repeat procedure with the 76 CPT modiﬁer.

**CPT Modiﬁer 77** – Repeat Procedure by Another Physician When a patient is taken back to surgery on the same day for the same or a related procedure by a different physician than the physician who performed the ﬁrst service, submit the repeat procedure with the 77 CPT modiﬁ er.

**Bundled Services CPT Code Description**:

99100 Special anesthesia service

99116 Anesthesia with hypothermia

99135 Special anesthesia procedure

99140 Emergency anesthesia

**Pre-Anesthetic Exams/Cancelled Surgery**

A pre-anesthetic examination and evaluation of a patient who does not undergo surgery may also be considered for payment. Payment is determined under the physician fee schedule for the medical or surgical service.

Non-medically directed Qualiﬁed Nonphysician Anesthetists should report the pre-anesthetic examination and evaluation for a patient whose surgery is cancelled using one of the subsequent hospital care CPT codes (99231–99233).

It is inappropriate to use the initial hospital care codes. No separate payment will be made in cases of medically directed Qualiﬁed Nonphysician Anesthetists because it is assumed the anesthesiologist furnished these services.

**Add-On Codes for Anesthesia**:

Anesthesia add-on codes are priced differently than multiple anesthesia codes. Only the base unit(s) of the add-on code will be allowed. All anesthesia time should be reported with the primary anesthesia code. See exception below in the obstetrical area.

Add-on codes for anesthesia involving burn excisions or debridement and obstetrical anesthesia are:

CPT Code Description 01952 Anesthesia, burn 4-9 percent – primary code

01953 Anesthesia, burn each 9 percent

– add-on code 01967 Neuraxial labor analgesia/anesthesia for planned vaginal deliver-primary code

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

addon code 01969 Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia– add-on code

The add-on codes should be billed in addition to the primary anesthesia code. For example, in the burn area, anesthesia time should be reported with CPT code 01952. Anesthesia time would not be reported with the add-on CPT code 01953. One unit (not time) per additional 9 percent total body surface area or part thereof should be reported with CPT code 01953. This would be reported in the Days/Units ﬁeld.

**Anesthesia Services Furnished by the Same Physician**:

Physicians who both perform and provide moderate sedation for medical/surgical services will be paid for the conscious sedation consistent with CPT guidelines. However, physicians who perform and provide local or minimal sedation for these procedures will not be paid separately for the sedation services.

The continuum of complexity in anesthesia services (from least intense to most intense) ranges from:

• Local or topical anesthesia

• Moderate (conscious) sedation

• Regional anesthesia

• General anesthesia

**Moderate sedation**

Moderate sedation is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. It does not include minimal sedation, deep sedation or monitored anesthesia care.

If the physician performing the procedure also provides moderate sedation for the procedure, payment may be made for conscious sedation consistent with CPT guidelines; however, if the physician performing the procedure provides local or minimal sedation for the procedure, no separate payment is made for the local or minimal sedation service.

**Monitored Anesthesia Care (MAC)**

Monitored Anesthesia Care (MAC) with advances in modern medical technology, there has been a shift in supplying some surgical and diagnostic services to an ambulatory, outpatient or ofﬁce setting. Accompanying this, there has been a change in the provision of anesthesia services from the traditional general anesthetic to a combination of anxiolytic, hypnotic, amnestic and analgesic drugs. Monitored Anesthesia Care (MAC) is a speciﬁc anesthesia service for a diagnostic or therapeutic procedure. Indications for monitored anesthesia care include the nature of the procedure, the patient’s clinical condition and/or the potential need to convert to a general or regional anesthetic.

Indications and Limitations of Coverage and/or Medical Necessity:

• In keeping with the American Society of Anesthesiologists’ standards for monitoring, MAC should be provided by qualiﬁed anesthesia personnel in accordance with individual state licensure. These individuals must be continuously present to monitor the patient and provide anesthesia care.

• During MAC, the patient’s oxygenation, ventilation, circulation and temperature should be evaluated by whatever methods are deemed most suitable by the attending anesthetist. It is anticipated that newer methods of non-invasive monitoring such as pulse oximetry and capnography will be frequently relied upon. Close monitoring is necessary to anticipate the need for general anesthesia administration or for the treatment of adverse physiologic reactions such as hypotension, excessive pain, difﬁculty breathing, arrhythmias, adverse drug reactions, etc. In addition, the possibility that the surgical procedure may become more extensive, and/ or result in unforeseen complications, requires comprehensive monitoring and/or anesthetic intervention.

The following CMS requirements for this type of anesthesia should be the same as for general anesthesia with regard to:

• The performance of pre-anesthetic examination and evaluation.

• The prescription of the anesthesia care required.

• The completion of an anesthesia record.

• The administration of necessary medications and the provision of indicated postoperative anesthesia care.

• Appropriate documentation must be available to reﬂect pre- and post-anesthetic evaluations and intraoperative monitoring.

• The MAC service rendered must be reasonable, appropriate and medically necessary.

• The anesthesia procedures listed in the LCD are examples of those that are usually provided by the attending surgeon and are included in the global fee and are not separately billable. In certain instances, however, MAC provided by anesthesia personnel, may be necessary for these procedures if the patient has one or more of the conditions or situations found in the ICD-10-CM Codes That Support Medical Necessity in the LCD. MAC may be necessary for these active and serious accompanying situations or conditions to ensure smooth anesthesia (and surgery) by the prevention of adverse physiologic complications. The use of anesthesia modiﬁers, when the CPT code is not fully descriptive, is required as follows:

* G8 Anesthesia HCPCS Modiﬁer – used to indicate certain deep, complex, complicated or markedly invasive surgical procedures. This modiﬁer is to be applied to the following anesthesia CPT codes only: 00100, 00300, 00400, 00160, 00532 and 00920.

• G9 Anesthesia HCPCS Modiﬁer – represents “a history of severe cardiopulmonary disease,” and should be utilized whenever the procedural list feels the need for MAC due to a history of advanced cardiopulmonary disease. The documentation of this clinical decision making process and the need for additional monitoring must be clearly documented in the medical record.

Special conditions and/or criteria must be supported by documentation in the medical record. Reimbursement for MAC will be the same amount allowed for full general anesthesia services if all the requirements listed under these indications are met. For procedures that do not usually require anesthesia services, MAC could be covered when the patient’s condition requires the presence of qualiﬁed anesthesia personnel to perform monitored anesthesia in addition to the physician performing the procedure, and is so documented in the patient’s medical record.

Note: The QS HCPCS modiﬁer must be used with the anesthesia service provided if MAC is delivered. This modiﬁer will follow the modiﬁer that indicates who provided the service (AA QS HCPCS modiﬁers).