RB.039.A Reporting Requirements for Anesthesia Services

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Version [A] Date : 10/16/2024
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PRODUCT VARIATIONS

This policy applies to all lines of business unless noted below.

Application of Claim Payment Policy is determined by benefits and contracts. Benefits may vary based on product line, group, or contract. Payment may vary based on individual contract.

POLICY STATEMENT

We apply the following Centers for Medicare & Medicaid Services (CMS) standard formula to calculate and determine allowance and reimbursement for eligible anesthesia services reported in minutes:

- (Time in Minutes/15 + Base Units) *x* Conversion Factor = Allowance.
- Time Units: The company calculates the reported time of anesthesia in minutes divided by 15 (rounded to two decimal place) to determine the time in units.
- Base units should not be reported with an anesthesia procedure code.

Time based Anesthesia Codes

Time-based anesthesia services must be reported in minutes in the 24h field of the professional claim form. If minutes are not reported appropriately in this field, the claim will deny.

Providers should report total minutes of anesthesia with the appropriate anesthesia procedure code. If the anesthesia service is discontinued or interrupted, the total number of minutes that anesthesia was administered should be reported.

ANESTHESIA FOR MULTIPLE PROCEDURES

Anesthesia administered for multiple covered procedures performed during the same operative session is covered and eligible for reimbursement consideration. Providers must report **only** the anesthesia procedure with the highest base unit, except for procedure codes identified as “add-on” codes (01953, 01968, 01969). The total time of anesthesia administration for the procedures should also be reported in the same line of the anesthesia procedure code with the highest base unit.

POLICY GUIDELINES

Global surgery rules do not apply to the procedure codes representing the administration of anesthesia.

Professional providers should report only the anesthesia procedure performed and, if appropriate, the total number of minutes. The company will apply all base and time unit conversion factors.

The conversion factor is the dollar value multiplied by the total units (time minutes/15 + base unit) to equal the reimbursement for most anesthesia services.

The physical status modifiers (P1-P6) identify levels of complexity of the anesthesia services and are reported in conjunction with anesthesia procedure codes when appropriate.

Anesthesia services performed in conjunction with non-covered procedures are not covered.

Payment will not be made when the anesthesiologist is involved in more than four anesthesia procedures concurrently.

CODING

Note: The Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), and the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) codes that may be listed in this policy are for reference purposes only.

Listing of a code in this policy does not imply that the service is covered and is not a guarantee of payment. Other policies and coverage guidelines may apply. When reporting services, providers/facilities should code to the highest level of specificity using the code that was in effect on the date the service was rendered. This list may not be all inclusive.

CPT Code	Eligible for reimbursement
00100-01999	Anesthesia code range

Modifier	Required Anesthesia Modifiers
AA	Anesthesia services performed personally by anesthesiologist
AD	Medical supervision by a physician: more than four concurrent anesthesia procedures

GC	This service has been performed in part by a resident under the direction of a teaching physician
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals
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

Modifier	**Physical Status Modifiers**
P1	A normal healthy patient
P2	A patient with mild systemic disease
P3	A patient with severe systemic disease
P4	A patient with severe 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

BENEFIT APPLICATION

This Reimbursement Policy does not constitute a description of benefits. Rather, this assists in the administration of the members' benefits which may vary by line of business. Applicable benefit

documents govern which services/items are eligible for coverage, subject to benefit limits, or excluded completely from coverage.

DEFINITIONS

N/A

DISCLAIMER

Approval or denial of payment does not constitute medical advice and is neither intended to guide nor influence medical decision making.

Policy Bulletins are developed by us to assist in administering plan benefits and constitute neither offers of coverage nor medical advice.

This Policy Bulletin may be updated and therefore is subject to change.

POLICY HISTORY

This section provides a high-level summary of changes to the policy since the previous version.

Summary	Version	Version Date
This is a new policy.	A	10/16/2024

REFERENCES

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7. Novitas Solutions: https://www.novitassolutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00144512