X.A. Anesthesia Billing

To bill for anesthesia services, use the five-digit CPT-4 anesthesia code applicable to the procedure with the appropriate anesthesia modifier. For anesthesia modifiers, see the *Approved Modifier (III.E.1) List* in this manual and the anesthesia modifiers charts below.

1. Anesthesia Procedure Codes

   The procedure codes accepted by Partnership Medi-Cal are the CPT anesthesia codes 00100-01999. Use the appropriate anesthesia modifier(s) indicated below.

Anesthesia Modifier Chart

ASA Ranking of Patient Physical Status	HCPCS Modifier	Added Units of Value
1. Normal, healthy patient or patient with mild systemic disease	P1 Elective or P1 with ET (Emergency)	0 1
2. Patient with severe systemic disease	P3 Elective or Emergency	2
3. Patient with severe systemic disease that is a constant threat to life	P4 Elective or P4 with ET (Emergency)	2 3
4. Moribund patient who is not expected to survive without the operation	P5 Elective or P5 with ET (Emergency)	4 5
Special Circumstances		
Other Hypothermia due to anesthesia	P4 with ICD-10-CM diagnosis code T88.51XA	5
Unusual position/field avoidance	22 Increased procedural services	1
Extracorporeal circulation	P4 with ICD-10-CM diagnosis code T81.89XA	10

CRNA Anesthesia Modifier Chart

ASA Ranking of Patient Physical Status	HCPCS Modifier	Added Units of Value
1. Normal, healthy patient or patient with mild systemic disease	P1 and QX or QZ Elective	0
	P1 and QX or QZ and ET Emergency	1
2. Patient with severe systemic disease	P3 and QX or QZ Elective or Emergency	2
3. Patient with severe systemic disease that is a constant threat to life	P4 and QX or QZ Elective	2
	P4 and QX or QZ and ET Emergency	3
4. Moribund patient who is not expected to survive without the operation	P5 and QX or QZ Elective	4
	P5 and QX or QZ and ET Emergency	5
Special Circumstances		
Total body hypothermia	P4 and QX or QZ with ICD-10-CM code T88.51XA	5
Unusual position/field avoidance	22 and QX or QZ	1
Extracorporeal circulation	P4 and QX or QZ with ICD-10-CM code T81.89XA	10

2. Billing Multiple Anesthesia Modifiers

When two or more modifiers are necessary to identify the anesthesia services, use modifier 99 with the appropriate five-digit CPT-4 anesthesia code and explain the applicable modifiers in the *Remarks* area/*Reserved For Local Use* field (Box 19) of the claim or as an attachment.

3. Split Cases for Anesthesia Services

An anesthesia split case occurs when one anesthesiologist begins a case and another anesthesiologist ends the case. This situation occurs most frequently when the anesthesia time is extensive, such as epidural anesthesia during labor and delivery.

The following detailed documentation is required for both anesthesiologists to be paid for services rendered.

- Both claim lines should be billed on the same claim form. If this is not possible (for example, the anesthesiologists do not belong to the same group), attach a copy of the other anesthesiologist's claim to the claim form.
- Use an appropriate anesthesia modifier for both claim lines. On an attachment, indicate that this is an anesthesia split case.
- Include the following in the *Remarks* area/*Reserved For Local Use* field (Box 19) of the claim or as an attachment to the paper claim:

Total length of anesthesia: START____ STOP____

Case started by Dr. _____ START____ STOP____

Actual time in attendance: _____ (minutes)

Case ended by Dr. _____ START____ STOP____

Actual time in attendance: _____ (minutes)

4. Surgical and Obstetrical Anesthesia

Operating surgeons and obstetricians providing their own regional anesthesia (for example, caudal or epidural) must bill the anesthesia on a separate claim line from the surgical services. Bill using the five-digit CPT-4 surgery code with modifier -47. Reimbursement for the service will be the basic unit value for anesthesia for the procedure without the added value of the duration of the anesthesia.

Local infiltration, uterine paracervical or pudendal block, digital block or topical anesthesia administered by the operating surgeon or the obstetrician are included in the reimbursement for the surgical or obstetrical procedure itself and are not separately reimbursable.

Providers billing codes 01958, 01960 – 01963, 01965, 01966, 01968 or 01969 for general anesthesia must document "start-stop" and total times on an attached anesthesia report only if the claim is for more than 40 units of time (10 hours). Providers billing these codes for regional or both general and regional anesthesia must document "time in attendance" (in addition to "start-stop" times for general anesthesia, if billed for both) on the anesthesia report.

5. Start, Stop and Total Anesthesia Time

Claims billing for more than 40 units of time (10 hours) require that an anesthesia report be attached to the claim. The anesthesia report must include anesthesia start, stop and total times.

6. Billing in 15-Minute Increments

To bill anesthesia time units, enter the number of 15-minute increments of anesthesia time in the *Service Units*/*Days* or *Units* box. Each 15-minute increment equals one time unit. Increments of time less than five minutes are not reimbursable except when the total anesthesia time being billed is less than five minutes. The last anesthesia time increment rendered may be rounded up to a whole unit if it equals or exceeds five minutes. If the last anesthesia time increment provided is less than five minutes, it may not be billed as an additional anesthesia time unit.

For CPT-4 code 01967 (neuraxial labor analgesia/anesthesia for planned vaginal delivery [includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor]), all claims of 20 units or more require that an anesthesia report be attached.

Note: Claims for 19 units or less for code 01967 do not require detailed documentation on the claim form or an attachment.

If billing for obstetrical regional anesthesia (CPT-4 code 01967), in addition to the documentation requirements noted above, providers also must document "time in attendance" (the actual time spent with the patient) in the *Remarks* area/*Reserved For Local Use* field (Box 19) of the claim. Claims without such documentation will be denied. Only actual time spent with the patient may be billed. If the actual time spent with the patient is less than the total quantity billed (in the *Service Units*/*Days* or *Units* box), the claim will be reimbursed according to the actual time spent with the patient.

Note: Do not include the base units for the procedure performed since the base unit payment is automatically included in the reimbursement rate. Billing for the base units could be considered a fraudulent billing practice.

7. Anesthesia Physician Reimbursement

The maximum reimbursement rates allowed for anesthesiologist services (CPT codes 00100 – 01999) are derived by adding the base unit (for the procedure code) plus the time units (15 minutes per unit) and multiplying by a conversion factor. An additional time unit may be billed only if the fractional time equals or exceeds five minutes, or if total anesthesia time is less than five minutes (*California Code of Regulations* [CCR], Title 22, Section 51505.2).

Pricing is based on Medi-Cal base units and fee schedule.

Total Units = Base Units + Plus Units (time) (+ or -) Modifier Units

8. Anesthesia CRNA Reimbursement

The maximum reimbursement rates allowed for Certified Registered Nurse Anesthetist (CRNA) services are derived by multiplying a per unit conversion factor by the sum of anesthesia basic units, minus one, and anesthesia time units. One anesthesia time unit represents each 15 minutes of anesthesia time, except when the anesthesia time is a fraction of 15 minutes. An additional time unit may be billed only if the fractional time equals or exceeds five minutes, or if total anesthesia time is less than five minutes (*California Code of Regulations* [CCR], Title 22, Section 51505.2).

9. Services Included in Basic Rate

Partnership Medi-Cal does not separately reimburse anesthesiologists for equipment necessary to render anesthesia or the interpretation of laboratory findings (such as blood gases or ECG) normally used by them in administering anesthesia. Reimbursement for these services is included in the reimbursement for the basic rate.

The complete evaluation routinely performed prior to the administration of anesthesia also is included in the basic rate. When billing consultation services (CPT-4 codes 99241 – 99275) and anesthesia services for the same recipient, by the same provider, for the same date of service, providers must state that the service was an actual consultation and not the complete pre-anesthesia evaluation in the *Remarks* area/*Reserved For Local Use* field (Box 19) of the claim or as an attachment.

10. Separately Reimbursable Anesthesia Services

Partnership separately reimburses for the following anesthesia services.

CPT-4 Code	Definition
36555	Insertion of non-tunneled centrally inserted central venous catheter, under 5 years of age
36556	age 5 years or older
36568	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; under 5 years of age
36569	age 5 years or older
36580	Replacement, complete, of a non-tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access
36584	Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access
36620	Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous
62324*	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance
62325*	with imaging guidance
62326*	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance
62327*	with imaging guidance
93503	Insertion and placement of flow directed catheter (for example, Swan-Ganz) for monitoring purposes

* Reimbursable only if the *Remarks* field (Box 80)/*Additional Claim Information* field (Box 19) of the claim, or a claim attachment, includes a statement that the epidural line was not used during the surgical procedure, but placed for post-operative management.

11. Anesthesiologist Present but not Administering Anesthesia

CPT-4 procedure code indicating consultation (99241 – 99275) or detention time (99360) may be used, depending on the service actually rendered. For example, an anesthesiologist might be required to attend a Computerized Tomography scan on a child in the event that anesthesia may be necessary.

If anesthesia is not needed, and therefore the anesthesiologist cannot bill for any other service during this time, detention time may be properly billed. The reason for detention or the nature of the consultation must be entered in the *Remarks* area/*Reserved For Local Use* field (Box 19) of the claim or as an attachment.

12. Pelvic Examination Under Anesthesia

Pelvic examination under anesthesia is by definition an independent procedure. However, when it is carried our as an integral part of a total service, it does not warrant a separate charge.

Therefore, a pelvic examination under anesthesia performed in conjunction with an induced abortion is not separately reimbursable under any circumstances. All claims submitted for a pelvic examination performed under anesthesia in combination with an induced abortion for the same patient on the same date of service will be denied.

13. Emergency Anesthesia Modifier: Healthy Patient:

Modifiers P1 and ET are billed together for anesthesia services during an emergency procedure on an otherwise healthy or medically stable and uncompromised patient. Examples of the appropriate use of modifiers P1 and ET are: an otherwise healthy adult patient who presents with acute appendicitis, a pediatric patient who presents with a torsion of the testis or a patient who requires a non-elective cesarean section. Modifier ET will add one unit to the anesthesia base unit value of any anesthesia service performed on a healthy patient in an emergency situation.

14. Supplies and Drugs Modifiers

Medi-Cal providers must bill with the following modifiers for supplies and drugs used in performing surgical procedures (CPT-4 codes 10000 – 69999):

Modifier	Definition
UA	**Medicaid level of care 10, as defined by each state**

To be used for surgical or non-general anesthesia related supplies and drugs, including surgical trays and plaster casting supplies, provided in conjunction with a surgical procedure code.

UB	**Medicaid level of care 11, as defined by each state**

To be used for surgical or general anesthesia related supplies and drugs, including surgical trays and plaster casting supplies, provided in conjunction with a surgical procedure code.

Note: Procedure code-supply modifier combination replaces the use of CPT-4 code 99070 for billing supplies related to surgical procedures. If CPT-4 code 99070 is used, the claim will be denied