Anesthesia Fee = ($32 x 3 Basic Value) + ($32 x 12 Time Unit Value) + ($32 x 0 Modifier Value) = $480

Required Modifiers

Modifiers are required when reporting anesthesia services. Services reported without the required modifiers will be paid at the lowest allowed percentage (50%). See the Modifier section for a description of the required modifiers. Listed below are reimbursement guidelines for anesthesia services performed by anesthesiologists and CRNAs.

Reimbursement for Anesthesia Administered by an Anesthesiologist

- Anesthesiologist services billed with modifier AA, reporting anesthesia services performed personally by the anesthesiologist, are reimbursed at 100 percent.

Reimbursement for Medical Direction of CRNA Services by an Anesthesiologist

- Anesthesiologist services billed with modifier QK, reporting the supervision of two to four CRNAs, are reimbursed at 50 percent.
- Anesthesiologist services billed with modifier AD, reporting the supervision of more than four CRNAs, where the anesthesiologist is not present at the time of induction, are paid as follows: (3 base units + time units) x 50%. When the anesthesiologist is present for induction, an additional time unit is paid when supporting documentation is submitted. Reimbursement is as follows: (3 Base + time units + 1 time unit for induction) x 50%.
- Anesthesiologist services billed with modifier QY reporting the supervision of one CRNA are reimbursed at 50 percent.

  Note: When an anesthesiologist, employing a CRNA, bills for anesthesia services, the anesthesiologist and CRNA are both reimbursed at 50 percent.

Reimbursement for Anesthesia Administered by a CRNA

- CRNA services billed with modifier QY, reporting medically directed services, are reimbursed at 50 percent.
- CRNA services billed with modifier QZ, reporting services without medical direction, are reimbursed at 100 percent

Second Attending Anesthesiologist or CRNA

When it is necessary to have a second attending anesthesiologist or CRNA assist with the preparation and conduction of anesthesia, these circumstances should be substantiated by special report. Reimbursement is as follows:

- In the case where an anesthesiologist assumes the role of second anesthesiologist, both anesthesiologists should report their services with modifier AA. The first anesthesiologist will be reimbursed for the full basic value plus time and modifying units at 100 percent. The second anesthesiologist will be reimbursed for a basic value of five units plus time and modifying units at 100 percent.
- When a CRNA assumes the role of second anesthesiologist, a medical direction situation does not exist and the anesthesiologist should bill with modifier AA and the CRNA should bill with modifier QZ. The first anesthesiologist will be reimbursed for the full basic value plus time and modifying units at 100 percent. The CRNA will be reimbursed for a basic value of five units plus time and modifying units at 100 percent.

Subsection B: Payment Modifiers for Anesthesia Services

All anesthesia services are reported by use of the anesthesia five-digit procedure code (00100–01999) plus the addition of a physical status modifier as outlined above. The added units for each physical status modifier are listed in the table in the physical status modifier section above.

It may be necessary to further modify listed services using CPT or HCPCS Level II modifiers. These modifiers indicate a service or procedure performed has been altered by some specific circumstance but has not changed its definition or code. The modifying circumstance shall be identified by the appropriate modifier following the procedure code. When two modifiers are applicable to a single code, indicate each modifier on the bill. If more than one modifier is used, place the "Multiple Modifiers" code 99 immediately after the procedure code. This indicates that one or more additional modifier codes will follow. Only certain modifiers in each of the categories (Evaluation and Management, Anesthesia, Surgery, Pathology/Laboratory, Radiology, General Medicine, and Physical Medicine) will be recognized for reimbursement purposes.

The modifiers listed below may differ from those published by the American Medical Association. Medical providers submitting workers' compensation billing shall use only the modifiers set out in the Medical Fee Guideline.

ANESTHESIA MODIFIERS

Under certain circumstances, medical services and procedures may need to be further modified. Modifiers commonly used in anesthesia are :

22 **Unusual Procedural Services:** When the service(s) provided is greater than that usually required for the

listed procedure, it may be identified by adding modifier 22 to the usual procedure number. A report may also be appropriate.

23 **Unusual Anesthesia:** Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding modifier 23 to the procedure code of the basic service.

47 **Anesthesia by Surgeon:** Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia. **Note:** Modifier 47 would not be used as a modifier for the anesthesia procedures 00100–01999. The operating surgeon should report the surgical procedure 10021–69990 with modifier 47 appended when billing for anesthesia services.

53 **Discontinued Procedure:** Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure. **Note:** This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

59 **Distinct Procedural Service:** Under certain circumstances, the medical provider may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.

AA **Anesthesia Services performed personally by the anesthesiologist:** Report modifier AA when the anesthesia services are personally performed by an anesthesiologist. Claims submitted with modifier AA are reimbursed at 100 percent.

AD **Medical Supervision by a Physician; More Than Four Concurrent Anesthesia Procedures:** Report modifier AD when the anesthesiologist supervises more than four concurrent anesthesia procedures. Claims submitted with modifier AD are reimbursed as described in the preceding section.

G8 **Monitored Anesthesia Care (MAC) for Deep, Complex, Complicated or Markedly Invasive Surgical Procedures:** Report modifier G8 when monitored anesthesia care is requied for deep, complex, complicated or markedly invasive surgical procedures.

G9 **Monitored Anesthesia Care for Patient Who Has a History of Severe Cardiopulmonary Condition:** Report modifier G9 when monitored anesthesia care is required for a patient who has a history of severe cardiopulmonary condition.

NT **No Time (State Specific Modifier):** If the surgeon or attending physician administers a local or regional block for anesthesia during a procedure, the bill should so indicate with the use of modifier NT for "no time."

QK **Medical Direction of Two, Three, or Four Concurrent Anesthesia Procedures Involving Qualified Individuals:** Report modifier QK when the anesthesiologist supervises two, three, or four concurrent anesthesia procedures. Claims submitted with modifier QK are reimbursed at 50 percent.

QS **Monitored Anesthesia Care Service:** The QS modifier is for informational purposes.

QX **CRNA Service with Medical Direction by a Physician:** Regional or general anesthesia provided by the CRNA with medical direction by a physician may be reported by adding modifier QX. Claims submitted with modifier QX are reimbursed at 50 percent.

QY **Medical Supervision by Physician of One CRNA:** Report modifier QY when the anesthesiologist supervises

one CRNA. Claims submitted with modifier QY are reimbursed at 50 percent.

QZ **CRNA Service without Medical Direction by a Physician:** Regional or general anesthesia provided by the CRNA without medical direction by a physician may be reported by adding modifier QZ. Claims submitted with modifier QZ are reimbursed at 100 percent.

Physical Status Modifiers

Six levels of physical status modifiers are consistent with the American Society of Anesthesiologists (ASA) ranking of patient physical status. Physical status is included to distinguish between various levels of complexity of the anesthesia service provided. A listing of physical status modifiers and the modifying units associated with each is provided in Subsection A, Payment Ground Rules for Anesthesia Services.

Qualifying Circumstances

Qualifying Circumstances that significantly impact the character of the anesthesia service provided and associated relative values are listed in Subsection A, Payment Ground Rules for Anesthesia Services.

Miscellaneous

Anesthesia Services Provided by the Operating Surgeon

Local infiltration, digital block, or topical anesthesia administered by the operating surgeon is included in the unit value for the surgical procedure.

If the attending surgeon administers anesthesia, the value shall be the lesser of the basic unit value without benefit for time or 25 percent of the total dollar value of the surgery. (See modifier 47 for guidelines on reporting administration of anesthesia by the attending surgeon.)

Major regional anesthesia administered by the surgeon, such as a spinal epidural or major peripheral nerve block, shall be reimbursed the basic anesthesia value only without benefit for time. (See modifier 47 for guidelines on reporting administration of anesthesia by the attending surgeon.)

If the surgeon or attending physician administers a local or regional block for anesthesia during a procedure, the bill should so indicate with the use of a modifier NT for "no time."

Nerve Block

For diagnostic or therapeutic nerve block, see 62310–62319 and 64400–64530.

For diagnostic or therapeutic nerve blocks performed by the surgeon, anesthesiologist, or CRNA, only one reimbursement per procedure shall be allowed, regardless of the time required (e.g., see codes 62310–62319, 64400–64530).

Field Avoidance

Any procedure around the head, neck, or shoulder girdle that requires field avoidance or any procedure compromising the anesthesia administration (e.g., requiring a position other than supine or lithotomy) has a minimum basic value of 5.0 units regardless of any lesser basic value assigned to such procedures. In this case, modifier 22 is required.

Multiple Procedures

Anesthesia reimbursement for multiple procedures is based on the procedure with the highest base value, plus modifying units (if appropriate), plus total time units for all combined surgical procedures.

No additional base value shall be reimbursed for anesthesia rendered during additional surgical procedures (other than the primary procedure) performed on the same day during the same operative setting.

Adjunctive Services

Adjunctive services provided during anesthesia and certain other circumstances may warrant an additional charge. Identify by using the appropriate unit value modifier.

Cardiopulmonary Resuscitation

For cardiopulmonary resuscitation (independent procedure), see 92950.

Time Units

In calculating units of time, use 10 minutes per unit. If a medical provider bills for a portion of 10 minutes, round the time up to the next 10 minutes and reimburse one unit for the portion of time. (See Subsection A, Payment Ground Rules for Anesthesia Services, for additional information on reporting of time units.)

ANESTHESIA

Medical Fee Schedule

CODE	MODIFIER	DESCRIPTION	BASE UNIT	FUD
00100		ANESTHESIA PROC SALIVARY GLANDS INCLUDING BIOPSY	5	
00102		ANES-PROC INVOLVING PLASTIC REPAIR CLEFT LIP	6	
00103		ANESTHESIA RECONSTRUCTIVE PROCEDURES OF EYELID	5	
00104		ANESTHESIA FOR ELECTROCONVULSIVE THERAPY	4	
00120		ANES-PROC EXTERNAL MIDDLE&INNER EAR INCL BX; NOS	5	
00124		ANES-PROC EXT MID&INNR EAR INCL BX; OTOSCOPY	4	
00126		ANES-PROC EXT MID&INNR EAR INCL BX; TYMPANOTOMY	4	
00140		ANESTHESIA FOR PROCEDURES ON EYE; NOS	5	
00142		ANESTHESIA FOR PROCEDURES ON EYE; LENS SURGERY		
00144		ANESTHESIA PROCEDURES ON EYE; CORNEAL TRANSPLANT	6	
00145		ANESTHESIA PROCEDURES EYE; VITREORETINAL SURGERY	6	
00147		ANESTHESIA FOR PROCEDURES ON EYE; IRIDECTOMY		
00148		ANESTHESIA FOR PROCEDURES ON EYE; OPHTHALMOSCOPY	4	
00160		ANESTHESIA PROC NOSE&ACCESSORY SINUSES; NOS	5	
00162		ANES-PROC NOSE&ACCESS SINUSES; RADICAL SURGERY	7	
00164		ANES-PROC NOSE&ACCESS SINUSES; BX SOFT TISSUE	4	
00170		ANES-INTRAORAL INCLUDING BIOPSY; NOS	5	
00172		ANES-INTRAORAL INCLUDING BX; REPAIR CLEFT PALATE	6	
00174		ANES-INTRAORL INCL BX; EXC RETROPHARYNG TUMR	6	
00176		ANES-INTRAORAL INCLUDING BIOPSY; RADICAL SURGERY	7	
00190		ANESTHESIA PROCEDURES FACIAL BONES OR SKULL; NOS	5	
00192		ANES-PROC FACIAL BONES/SKULL; RADICAL SURGERY	7	
00210		ANES-INTRACRAN; NOT OTHERWISE SPECIFIED	11	
00212		ANES-INTRACRAN; SUBDURAL TAPS	5	
00214		ANES-INTRACRAN; BURR HOLES INCL VENTRICULOGRAPHY	9	
00215		ANES-INTRACRAN;PLASTY/ELEV SKULL FX-XTRADURL	9	
00216		ANES-INTRACRAN; VASCULAR PROCEDURES	15	
00218		ANES-INTRACRAN; PROCEDURES IN SITTING POSITION	13	
00220		ANES-INTRACRAN; CEREBROSP FL SHUNTING PROCEDURES	10	
00222		ANES-INTRACRAN; ELECTROCOAGULAT INTRACRAN NERVE	6	
00300		ANES-INTEG SYST MUSC&NERV HEAD NECK TRUNK;NOS	5	
00320		ANES-PROC ESOPH THYRD TRACHEA&LYMPH; NOS 1 YR/>	6	
00322		ANES-PROC ESOPH THYROID TRACH LYMPH;BX THYROID	3	
00326		ANES-ON THE LARYNX&TRACHEA CHILDREN < 1 YEAR AGE		
00350		ANESTHESIA PROCEDURES MAJOR VESSELS OF NECK; NOS	10	
00352		ANES-PROC MAJOR VESSELS NECK; SIMPLE LIGATION	5	
00400		ANES-PROC INTEG SYS EXTREM ANT TRNK&PERIN; NOS	3	
00402		ANES-INTEG SYST EXTREM TRUNK PERIN;BREAST RECON	5	
00404		ANES-INTEG EXTREM TRUNK;RADL/MOD RAD BREAST PROC	5	
00406		ANES-INTEG EXTREM TRUNK;RADL BRST W/NODE DISSECT	13	
00410		ANES-INTEG EXTREM TRUNK PERINEM;CONVERT ARRYTH	4	
00450		ANESTHESIA PROCEDURES CLAVICLE AND SCAPULA; NOS	5	
00452		ANES-PROC CLAVICLE&SCAPULA; RADICAL SURGERY	6	
00454		ANES-PROC CLAVICLE&SCAPULA; BIOPSY CLAVICLE	3	
00470		ANESTHESIA FOR PARTIAL RIB RESECTION; NOS	6	

+ Add on Procedure

⊘ Modifier 51 Exempt Procedure