Washington State Department of
Labor & Industries
Workers' Compensation Services

Payment Policies for Healthcare Services
Provided to Injured Workers and Crime Victims

Chapter 4: Anesthesia Services

Effective July 1, 2016

Link: Look for possible **updates and corrections** to these payment policies at:

www.lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/2016/

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Definitions

- **CPT® and HCPCS code modifiers mentioned in this chapter:**

–25 **Significant, separately identifiable evaluation and management (E/M) service by the same physician on the day of a procedure**

Payment is made at 100% of the fee schedule level or billed charge, whichever is less.

–47 **Anesthesia by surgeon**

–99 **Multiple modifiers**

This modifier should only be used when two or more modifiers affect payment. Payment is based on the policy associated with each individual modifier that describes the services performed. For billing purposes, only **modifier –99** should go in the modifier column, with the individual descriptive modifiers that affect payment listed elsewhere on the billing form.

–AA **Anesthesia services performed personally by anesthesiologist**

–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**

–QK **Medical direction of 2, 3, or 4 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**

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Payment policy: All anesthesia services

Who must perform these services to qualify for payment

Payment for anesthesia services will only be made to:

- Anesthesiologists, *and*
- Certified registered nurse anesthetists.

Services that can be billed

Most anesthesia services are paid with base and time units. These services should be billed with CPT® anesthesia codes **00100** through **01999** and the appropriate anesthesia modifier.

Some selected services are paid using the RBRVS method.

Note: For information on **base and time units** and **RBRVS** methods for anesthesia services, see other payment policy sections of this chapter.

Services that aren't covered

Anesthesia isn't payable for procedures that aren't covered.

The insurer doesn't cover anesthesia assistant services.

Payment for CPT® codes **99100, 99116, 99135**, and **99140** is considered bundled and isn't payable separately.

CPT® physical status **modifiers** (**–P1** to **–P6**) and CPT® 5-digit **modifiers** aren't accepted.

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Requirements for billing

Anesthesia add-on codes

Anesthesia add-on codes must be billed with a primary anesthesia code. There are three anesthesia add-on CPT® codes: **01953, 01968**, and **01969**:

- Add-on code **01953** should be billed with primary code **01952**,
- Add-on codes **01968** and **01969** should be billed with primary code **01967**,
- Add-on codes **01968** and **01969** should be billed in the same manner as other anesthesia codes paid with base and time units.

Note: Providers should report the total time for the add-on procedure (in minutes) in the Units column (Field 24G) of the **CMS 1500** form (F245-127-000).

Anesthesia for burn excisions or debridement (CPT® add-on code 01953)

The anesthesia add-on code for burn excision or debridement must be billed as follows:

If the **total body surface area** is…	Then the **primary code** to bill is:	And the **units to bill of add-on code 01953** is:
Less than 4 percent	**01951**	None
4 - 9 percent	**01952**	None
Up to 18 percent	**01952**	1
Up to 27 percent	**01952**	2
Up to 36 percent	**01952**	3
Up to 45 percent	**01952**	4
Up to 54 percent	**01952**	5
Up to 63 percent	**01952**	6
Up to 72 percent	**01952**	7
Up to 81 percent	**01952**	8
Up to 90 percent	**01952**	9
Up to 99 percent	**01952**	10

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Anesthesia base units

List only the time in minutes on your bill. Don't include the base units (L&I's payment system automatically adds the base units).

Note: Most of L&I's anesthesia base units are the same as the units adopted by CMS. L&I differs from the CMS base units for some procedure codes based on input from the ATAG (see more about the ATAG in Additional information: How anesthesia payment policies are established, below).

Link: The anesthesia codes, base units, and base sources are listed in the Professional Services Fee Schedule, available at: http://feeschedules.Lni.wa.gov.

Anesthesia time

Anesthesia must be billed in one-minute time units. Anesthesia time:

- **Begins** when the anesthesiologist or CRNA starts to physically prepare the patient for the induction of anesthesia in the operating room area (or its equivalent), *and*
- **Ends** when the anesthesiologist or CRNA is no longer in constant attendance (when the patient can be safely placed under postoperative supervision).

Anesthesia billing code modifiers for anesthesia paid with base and time units

When billing for anesthesia services paid with base and time units, anesthesiologists and CRNAs should use the CPT® or HCPCS **modifiers** in the following table.

Note: For complete **modifier** descriptions and instructions, refer to a current CPT® or HCPCS book.

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Note: Except for **modifier –99**, the **modifiers** listed in the following table aren't valid for anesthesia services paid by the RBRVS method.

For use by:	CPT® or HCPCS code modifier	Brief description	Notes:
Anesthesiologists and CRNAs	**–99**	Multiple modifiers	Use this modifier when 5 or more modifiers are required. Enter **–99** in the modifier column on the bill. List individual descriptive modifiers elsewhere on the billing document.
Anesthesiologists	**–AA**	Anesthesia services performed personally by anesthesiologist	—
	–QK	Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individual	Payment based on policies for team services (see Team care payment policy at the end of this chapter).
	–QY	Medical direction of 1 CRNA for a single anesthesia procedure	Payment based on policies for team services (see Team care payment policy at the end of this chapter).
CRNAs[(1)]	**–QX**	CRNA service: with medical direction by a physician	Payment based on policies for team services (see Team care payment policy at the end of this chapter).
	–QZ	CRNA service: without medical direction by a physician[(1)]	Maximum payment is 90% of the maximum allowed for physician services.

[(1)] Bills from CRNAs that don't contain a modifier are paid based on payment policies for team services (see Team care payment policy at the end of this chapter).

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Payment limits

Payment for local, regional or digital block, or general anesthesia administered by the surgeon is included in the RBRVS payment for the procedure.

Note: Patient acuity doesn't affect payment levels.

Services billed with **modifier –47** (anesthesia by surgeon) are considered bundled and aren't payable separately.

Services billed with CPT® 5-digit **modifiers** and physical status **modifiers** (**–P1** through **–P6**) aren't paid.

CRNA services are paid at a maximum of 90% of the allowed fee that would be paid to a physician.

Note: CRNA services shouldn't be reported on the same **CMS-1500** form used to report anesthesiologist services.

Links: For licensed nursing rules, see WAC 296-23-240.

For licensed nursing billing instructions, see WAC 296-23-245.

For detailed billing instructions, including examples of how to submit bills, refer to L&I's **General Provider Billing Manual** (form F248-100-000).

Payment policy: Base and time units payment method for anesthesia

How to calculate anesthesia payment paid with base and time units

Providers are paid the lesser of their charged amount or L&I's maximum allowed amount.

The maximum payment for services provided by a CRNA is 90% of the maximum payment for a physician.

For services provided on or after July 1 2016, the anesthesia conversion factor is **$51.15** per 15 minutes (**$3.41** per minute).

Link: The anesthesia conversion factor is published in WAC 296-20-135.

The maximum payment for anesthesia services paid with base and time units is calculated using the:

- Base value for the procedure, *and*
- Time the anesthesia service is administered, *and*
- L&I anesthesia conversion factor.

To determine the maximum payment for physician services:

1. Multiply the base units listed in the fee schedule by 15, *then*
2. Add the value from step 1 to the total number of whole minutes, *then*
3. Multiply the result from step 2 by **$3.41**.

   Example: CPT® code **01382** (anesthesia for knee arthroscopy) has three anesthesia base units. If the anesthesia service takes 60 minutes, the maximum physician payment would be calculated as follows:

   1. 3 base units x 15 = 45 base units,
   2. 45 base units + 60 time units (minutes) = 105 base and time units,
   3. Maximum payment for physicians = 105 x **$3.41** = **$358.05**.

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Payment policy: RBRVS payment method for anesthesia

Which services are paid using the RBRVS method

Some services commonly performed by anesthesiologists and CRNAs are paid using the RBRVS payment method, including:

- Anesthesia evaluation and management services, *and*
- Most pain management services, *and*
- Other selected services.

Injection code treatment limits

If the **injection type** is…	Then the **treatment limit** is:
Epidural and caudal injections of substances other than anesthetic or contrast solution	**Limited** to 2 injections, same side, per date of service **Limited** to 3 injections per 6 months; 3rd requires documented improvement **Limited** to 4 injections per 365 day-period
Facet injections	**Not covered**, except in preparation for facet neurotomy. Limited to 2 joint levels bilaterally, or 3 unilaterally per day of service.
Intramuscular injections of steroids and other nonscheduled medications.	**Maximum of 6** injections per patient are allowed.
Dry needling and trigger point injections without medications	**Maximum of 6** sessions per patient per claim.

Dry needling is considered a variant of trigger point injections with medications. It is a technique where needles are inserted (no medications are injected) directly into trigger point locations, as opposed to the distant points or meridians used in acupuncture.

Note: L&I doesn't cover acupuncture services (see WAC 296-20-03002(2)).

Links: Details regarding treatment guidelines and limits for the injections listed above can also be found in WAC 296-20-03001(7) (for example, dry needling follows the same rules as trigger point injections).

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For information on billing for medications, see Chapter 16: Medication Administration and Injections.

Requirements for billing

Dry needling of trigger points should be billed using trigger point injection codes.

The office notes or report must document the objective and subjective findings used to determine the need for the procedure and any future treatment plan or course of action.

When billing for services paid with the RBRVS method, enter the total number of times the procedure is performed in the Units column (Field 24G on the **CMS-1500 form**).

Link: Maximum fees for services paid by the RBRVS method are located in the Professional Services Fee Schedule, available at http://feeschedules.Lni.wa.gov.

When using **modifiers**:

- Anesthesia **modifiers –AA**, **–QK**, **–QX**, **–QY**, and **–QZ** aren't valid for services paid by the RBRVS method.

  For a complete list of modifiers and descriptions, see a current CPT® or HCPCS book.

An E/M service is payable on the same day as a pain management procedure only when:

- It is the patient's initial visit to the provider who is performing the procedure, *or*
- The E/M service is clearly separate and identifiable from the pain management procedure performed on the same day, and meets the criteria for an E/M service.

Link: For more information on using the **–25 modifier**, see the All E/M services payment policy section of Chapter 10: Evaluation and Management (E/M) Services chapter.

The use of E/M codes on days after the procedure is performed is subject to the global surgery policy.

Link: For more information, see the Global surgery payment policy section of Chapter 29: Surgery Services .

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Payment limits

Anesthesia teaching physicians

Teaching physicians may be paid at the personally performed rate when the physician is involved in the training of physician residents in:

- A single anesthesia case, *or*
- Two concurrent anesthesia cases involving residents, *or*
- A single anesthesia case involving a resident that is concurrent to another case paid under the medical direction rules.

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Payment policy: Team care (Medical direction of anesthesia)

Requirements for medical direction of anesthesia

Physicians directing qualified individuals performing anesthesia must:

- Perform a pre-anesthetic examination and evaluation, *and*
- Prescribe the anesthesia plan, *and*
- Participate in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence, *and*
- Make sure any procedures in the anesthesia plan that he/she doesn't perform are performed by a qualified individual as defined in program operating instructions, *and*
- Monitor the course of anesthesia administration at frequent intervals, *and*
- Remain physically present and available for immediate diagnosis and treatment of emergencies, *and*
- Provide indicated postanesthesia care.

In addition, physicians directing anesthesia:

- May direct no more than 4 anesthesia services concurrently, *and*
- May not perform any other services while directing the single or concurrent services.

The physician may attend to medical emergencies and perform other limited services as allowed by Medicare instructions and still be deemed to have medically directed anesthesia procedures.

Documentation requirements for team care

Documentation requirements for team care

The physician must document in the patient's medical record that the medical direction requirements were met. The physician doesn't submit documentation to the insurer, but must make it available upon request.

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Requirements for billing

When billing for team care situations:

- Anesthesiologists and CRNAs must report their services on separate **CMS-1500** forms using their own provider account numbers,
- Anesthesiologists must use the appropriate **modifier** for medical direction or supervision (**–QK** or **–QY**),
- CRNAs should use **modifier –QX**.

How to calculate payment for team care

To determine the maximum payment for team care services:

- Calculate the maximum payment for solo physician services (see the How to calculate anesthesia payment paid with base and time units in the payment policy for Base and time units payment method for anesthesia section of this chapter),
- The maximum payment to the physician is 50% of the maximum payment for solo physician services,
- The maximum payment to the CRNA is 45% of the maximum payment for solo physician services (90% of the other 50% share).

Additional information: How team care policies are established

L&I follows CMS's policy for team care (medical direction of anesthesia).

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Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules for acupuncture services non-coverage	Washington Administrative Code (WAC) 296-20-03002(2): http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-03002
Administrative rules for anesthesia	Washington Administrative Code (WAC) 296-20: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20
Administrative rules for licensed nursing	Washington Administrative Code (WAC) 296-23-240: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-23-240
Administrative rules for licensed nursing billing instructions	Washington Administrative Code (WAC) 296-23-245: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-23-245
Administrative rules for treatment guidelines for injections	Washington Administrative Code (WAC) 296-20-03001(7): http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-03001
Anesthesia **conversion factor**	Washington Administrative Code (WAC) 296-20-135: http://apps.leg.wa.gov/WAC/default.aspx?cite=296-20-135
Becoming an L&I Provider	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/Becoming/
Billing instructions and forms	Chapter 2: Information for All Providers
Coverage decisions for spinal injections	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/TreatingPatients/ByCondition/SpinalInjections
Payment policies for **billing for medications**	Chapter 16: Medication Administration and Injections
Payment policies for **global surgery**	Chapter 29: Surgery Services
Payment policies for **using billing code modifier –25**	Chapter 10:

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	Evaluation and Management (E/M) Services
Professional Services **Fee Schedules**	L&I's website: http://feeschedules.Lni.wa.gov

Need more help? Call L&I's Provider Hotline at **1-800-848-0811**

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