

ANESTHESIA SERVICES

Anesthesia payment policies are established by L&I with input from the Reimbursement Steering Committee (RSC) and the Anesthesia Technical Advisory Group (ATAG). The RSC is a standing committee with representatives from L&I, DSHS and HCA. The ATAG includes anesthesiologists, CRNAs and billing professionals.

NONCOVERED AND BUNDLED SERVICES

Anesthesia Assistant Services

The insurer doesn't cover anesthesia assistant services.

Noncovered Procedures

Anesthesia isn't payable for procedures that **aren't covered** by L&I. Refer to **Appendix D** for a list of noncovered procedures.

Patient Acuity

Patient acuity doesn't affect payment levels. 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.

Payment for Anesthesia

Payment for anesthesia services will only be made to anesthesiologists and certified registered nurse anesthetists.

Payment for local, regional or digital block, or general anesthesia administered by the surgeon is included in the RBRVS payment for the procedure. Services billed with modifier –47 (anesthesia by surgeon) are considered bundled and aren't payable separately.

CERTIFIED REGISTERED NURSE ANESTHETISTS (CRNA)

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

Refer to [WAC 296-23-240](#) for licensed nursing rules and [296-23-245](#) for licensed nursing billing instructions. For more detailed billing instructions, including examples of how to submit bills, refer to L&I's CMS-1500 billing instructions (publication F248-094-000).



CRNA services shouldn't be reported on the same CMS-1500 form used to report anesthesiologist services; this applies to solo CRNA services as well as team care.

MEDICAL DIRECTION OF ANESTHESIA (TEAM CARE)

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

Requirements for Medical Direction of Anesthesia

Physicians directing qualified individuals performing anesthesia must:

- Perform a preanesthetic 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
- Can't 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

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

Billing for Team Care

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.

Payment for Team Care

To determine the maximum payment for team care services:

- Calculate the maximum payment for solo physician services.
(Refer to [Anesthesia Payment Calculation](#) in the Anesthesia Services Paid with Base and Time Units section, page 60)
- 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).

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.

ANESTHESIA SERVICES PAID WITH BASE AND TIME UNITS

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.

Anesthesia Base Units

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. The anesthesia codes, base units and base sources are listed in the Professional Services Fee Schedule.

Anesthesia Time

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).

Anesthesia time ends when the anesthesiologist or CRNA is no longer in constant attendance (when the patient can be safely placed under postoperative supervision). Anesthesia must be billed in one-minute time units.



List only the time in minutes on your bill. Don't include the base units. They are automatically added by L&I's payment system.

Anesthesia Modifiers

Anesthesiologists and CRNAs should use the modifiers in this section when billing for anesthesia services paid with base and time units. Except for modifier –99, these modifiers aren't valid for anesthesia services paid by the RBRVS method.

Services billed with CPT® 5-digit modifiers and physical status modifiers (P1 through P6) **aren't** paid. Refer to a current CPT® or HCPCS book for complete modifier descriptions and instructions.

CPT® Modifier

For Use By	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.

HCPCS Modifiers

For Use By	Modifier	Brief Description	Notes
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.
	–QY	Medical direction of 1 CRNA for a single anesthesia procedure	Payment based on policies for team services.
CRNAs*	–QX	CRNA service: with medical direction by a physician	Payment based on policies for team services.
	–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.

Anesthesia Payment Calculation

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

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

The anesthesia conversion factor is published in [WAC 296-20-135](#). For services provided on or after July 1, 2010, the anesthesia conversion factor is \$47.85 per 15 minutes (\$3.19 per minute). Providers are paid the lesser of their charged amount or L&I's maximum allowed amount.

To determine the maximum payment for physician services:

1. Multiply the base units listed in the fee schedule by 15.
2. Add the value from step 1 to the total number of whole minutes.
3. Multiply the result from step 2 by \$3.19.

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

Example: CPT[®] code 01382 (anesthesia for knee arthroscopy) has 3 anesthesia base units. If the anesthesia service takes 60 minutes, the maximum physician payment would be calculated as follows:

1. Base units x 15 = 3 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 \$3.19 = \$334.95

ANESTHESIA ADD-ON CODES

Anesthesia add-on codes must be billed with a primary anesthesia code. There are 3 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.

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

Anesthesia for Burn Excisions or Debridement

The anesthesia add-on code for burn excision or debridement, CPT[®] code 01953, must be billed according to the instructions in the following table.

Total Body Surface Area	Primary Code	Units of Add-On Code 01953
Less than 4 percent	01951	None
5 - 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

ANESTHESIA SERVICES PAID BY THE RBRVS METHOD

Some services commonly performed by anesthesiologists and CRNAs aren't paid with anesthesia base and time units. These services include:

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

Modifiers

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

Refer to a current CPT® or HCPCS book for a complete list of modifiers and descriptions. Refer to **Appendix E** for a list of modifiers that affect payment.

Maximum Payment

Maximum fees for services paid by the RBRVS method are located in the Professional Services Fee Schedule.



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 bill form).

E/M Services Payable with Pain Management Procedures

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. (see Using the -25 modifier)

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. The use of E/M codes on days after the procedure is performed is subject to the global surgery policy (refer to the Surgery Services section).

Injection Code Treatment Limits

Details regarding treatment guidelines and limits for the following kinds of injections can also be found in [WAC 296-20-03001](#). Refer to [Medication Administration](#) in the Other Medicine Services section; page **91** for information on billing for medications.

Injection	Treatment Limit
Epidural and caudal injections of substances other than anesthetic or contrast solution	Maximum of 6 injections per acute episode are allowed.
Facet injections	Maximum of 4 injection procedures per patient are allowed.
Intramuscular and trigger point injections of steroids and other nonscheduled medications and trigger point dry needling ⁽¹⁾	Maximum of 6 injections per patient are allowed.

- (1) 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. L&I doesn't cover acupuncture services ([WAC 296-20-03002](#)). Dry needling of trigger points should be billed using trigger point injection codes. Dry needling follows the same rules as trigger point injections in [WAC 296-20-03001](#) (14).