

CAUTION: Read the [ICD-9 Policy Holding Library](#) page about policy in this document.

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Anesthesia

This section is to assist providers in completing claims for anesthesia services. Medi-Cal has not adopted the “qualifying circumstances” codes (99100 – 99140). Claims submitted with these codes will be denied or returned to the provider for correction. For additional help, refer to the *Anesthesia Billing Examples* section of this manual.

Billing Anesthesia Services

Anesthesia services (CPT-4 codes 00100 – 01999) are reimbursed when medically necessary. To bill for anesthesia services, use the five-digit CPT-4 code applicable to the procedure with the appropriate modifier. For anesthesia modifiers, see *Modifiers: Approved List* in this manual and the anesthesia modifiers charts in this section.

Billing in 15-Minute Increments of Anesthesia Time

To bill anesthesia time units, enter the number of 15-minute increments of anesthesia time in the *Service Units/Days or Units* box on the claim form, using the same billing line as the procedure code. Each 15-minute increment equals one time unit.

Note: Providers who bill electronically for anesthesia are required to submit in minutes, as units will no longer be accepted in the 837P transaction. In addition, start and stop times are no longer required. There are no changes to billing anesthesia via paper claims. For electronic billing information providers should refer to the *Medi-Cal Computer Media Claims Technical Manual*, which is accessible through the Medi-Cal website.

Increments of time less than five minutes are not reimbursable except when the total anesthesia time being billed is less than five minutes. For more information, see “Total Anesthesia Time Unit: Less Than Five Minutes” in this section.

Total Anesthesia Time Unit: More 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.

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Time Unit Billing Examples

Time unit examples:

- For 49 minutes of anesthesia time actually spent with the patient, enter 3 in the *Service Units/Days or Units* box. (The four-minute increment is not reimbursable.)
- For 80 minutes of anesthesia time actually spent with the patient, enter 6 in the *Service Units/Days or Units* box. (The five-minute increment is reimbursable.)

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.

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.

CPT-4 Code 01967 Billing Requirements:

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

“Time in Attendance” With the Patient

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” on the attached anesthesia report. Claims without such documentation will be denied. Only time in attendance with the patient may be billed.

“Time in attendance” is time when the anesthesiologist or Certified Registered Nurse Anesthetist (CRNA) monitors the patient receiving neuraxial labor analgesia, and the anesthesiologist or CRNA is readily and immediately available in the labor or delivery suite. If the actual time in attendance is less than the total quantity billed (in either the *Service Units* or *Days or Units* box), the claim will be reimbursed for the time in attendance with the patient. If two or more patients receive neuraxial analgesia concurrently, no more than four total time units per hour may be billed and must be apportioned among the claims, including claims to other insurance carriers.

Example: Patients A and B receive overlapping labor analgesia: Patient A from 0500 to 1415 and Patient B from 0930 to 1245. See the following sets of instruction to bill for patient A and patient B.

Patient A claim completion instructions:

Field/Claim Type	Enter
<i>Service Units</i> field (Box 46) on the <u>UB-04</u> claim <i>Days or Units</i> field (Box 24G) on the <u>CMS-1500</u> claim	31
<i>Remarks</i> field (Box 80) on the <u>UB-04</u> claim <i>Reserved for Local Use</i> field (Box 19) on the <u>CMS-1500</u> claim	SEE ATTACHMENT

Required documentation will not fit in the designated area of the claim, so providers should enter the words “See Attachment” in the *Remarks* field (Box 80)/*Reserved for Local Use* field (Box 19) of the claim. For this example providers would submit the following exact statement on an attachment to the claim (following specific instructions under “Attachments” in the *Forms: Legibility and Completion Standards* section of this manual):

Epidural anesthesia start time: 0500. Stop time: 1415.
 Time in attendance: 458 minutes (0500 – 0930 = 270 minutes;
 0930 – 1245 = 195 minutes, divided by 2 for overlapping
 time = 98 minutes; 1245 – 1415 = 90 minutes. 270+98+90 = 458)

Patient B claim completion instructions:

Field/Claim Type	Enter
<i>Service Units</i> field (Box 46) on the UB-04 claim <i>Days or Units</i> field (Box 24G) on the CMS-1500 claim	7
<i>Remarks field (Box 80)</i> on the UB-04 claim form <i>Reserved for Local Use</i> field (Box 19) on the CMS-1500 claim	SEE ATTACHMENT

Required documentation will not fit in the designated area of the claim, so providers should enter the words “See Attachment” in the *Remarks* field (Box 80)/*Reserved for Local Use* field (Box 19) of the claim. For this example providers would submit the following exact statement on an attachment to the claim (following specific instructions under “Attachments” in the *Forms: Legibility and Completion Standards* section of this manual):

Epidural anesthesia start time: 0930. Stop time: 1245. Time in attendance: 98 minutes (0930 – 1245 = 195 minutes, divided by 2 to split overlapping time = 98 minutes).

Obstetrical Anesthesia Documentation	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.
Billing Obstetrical Anesthesia Add-On Codes	Add-on codes must be billed in conjunction with the primary anesthesia code. For an example, refer to the <i>Anesthesia Billing Examples</i> section of this manual.
Total Anesthesia Time Unit: Less Than Five Minutes	<p>The preceding policy applies to all anesthesia services, except when the total anesthesia time being billed is less than five minutes. In these situations, one increment of anesthesia time is reimbursable.</p> <p>When billing for anesthesia time that is less than five minutes, enter 1 in the <i>Service Units/Days or Units</i> box of the claim. Do not include the base unit for the procedure performed. Refer to the <i>Rates: Maximum Reimbursement</i> section in this manual for information about how anesthesia reimbursement is calculated.</p>

Intravenous Sedation and General Anesthesia Guidelines for Dental Procedures

Patient selection for conducting dental procedures under IV sedation or general anesthesia utilizes medical history, physical status, and indications for anesthetic management. The dental provider in consultation with an anesthesiologist is responsible for determining whether a Medi-Cal beneficiary meets the minimum criteria necessary for receiving IV sedation or general anesthesia. The dental provider must also submit a Treatment Authorization Request (TAR) prior to delivering IV sedation or general anesthesia. However, a TAR is not required prior to delivering IV sedation or general anesthesia as part of an outpatient dental procedure in a nursing facility or any category of intermediate care for the developmentally disabled. Additionally, the dental provider must meet the requirements for chart documentation, which includes a copy of a complete history and physical examination, diagnosis, treatment plan, radiological reports, the indication for IV sedation or general anesthesia and documentation of perioperative care (preoperative, intraoperative and postoperative care) for the dental procedure.

Criteria Indications for IV Sedation or General Anesthesia

Behavior modification and local anesthesia shall be attempted first. If this fails or is not possible, then sedation shall be considered.

If the provider documents both number 1 and number 2 below, then the patient shall be considered for IV sedation or general anesthetic.

1. Failure of local anesthesia to control pain.
2. Failure of conscious sedation, either inhalation or oral.

If the provider documents any one of numbers 3 through 6 then the patient shall be considered for IV sedation or general anesthetic.

3. Failure of effective communicative techniques and the inability for immobilization (patient may be dangerous to self or staff).
4. Patient requires extensive dental restorative or surgical treatment that cannot be rendered under local anesthesia or conscious sedation.
5. Patient has acute situational anxiety due to immature cognitive functioning.
6. Patient is uncooperative due to certain physical or mental compromising conditions.

If sedation is indicated then the least profound procedure shall be attempted first. The procedures are ranked from low to high profundity in the following order: conscious sedation via inhalation or oral anesthetics, IV sedation, then general anesthesia.

Patients with certain medical conditions such as but not limited to: moderate to severe asthma, reactive airway disease, congestive heart failure, cardiac arrhythmias and significant bleeding disorders (continuous Coumadin therapy) should be treated in a hospital setting or a licensed facility capable of responding to a serious medical crisis.

Providers will adhere to all regulatory requirements (federal, state, licensing board, etc.) for:

- Preoperative and perioperative care
- Monitoring and equipment requirements
- Emergencies and transfers
- Monitoring guidelines

References

1. American Academy of Pediatric Dentistry (AAPD) – www.aapd.org
2. American Dental Board of Anesthesiology (ADBA) – www.adba.org
3. American Dental Society of Anesthesiology (ADSA) – www.adsahome.org
4. American Society of Anesthesiologists (ASA) – www.asahq.org
5. American Association of Nurse Anesthetists (AANA) – www.aana.com/resources2/professionalpractice
6. Dental Board of California – www.dbc.ca.gov/licensees/dds/permits_ga.shtml
7. National Network for Oral Health Access (NNOHA) – www.nnoha.org/nnoha-content/uploads/2013/07/White-Paper-Health-Centers-and-Hospital-Based-Dentistry.pdf
8. Cochrane Database of Systematic Reviews 2012 – www.update-software.com/BCP/WileyPDF/EN/cd006334.pdf
9. National Guideline Clearinghouse (NGC) – www.guideline.gov/content.aspx?id=34767&search=general+anesthesia+dental+pediatric
10. US National Library of Medicine National Institutes of Health – www.ncbi.nlm.nih.gov/pubmed/23152234

**Mobile Dental
Anesthesia Services**

Physician anesthesiologists provide general anesthesia as defined in the CPT-4 procedure manual. Mobile dental anesthesia services are provided by an anesthesiologist in an office with the anesthesiologist supplying the necessary equipment and supplies in order to create an environment equivalent to an outpatient or hospital environment. A current General Anesthesia Permit from the Dental Board of California (DBC) is required to provide this service. The *Application for a General Anesthesia Permit* (Form GA-1) is available on the DBC website.

The anesthesiologist's time should be billed with the appropriate anesthesia CPT-4 procedure code in range 00100 – 01999. Medi-Cal guidelines for anesthesia services and billing must be followed. Only anesthesia services which are appropriate and safe for the clinic/office environment may be delivered at that site.

The following are services and supplies that may be reimbursed for mobile dental anesthesia:

Telephone Call(s) for
Pre-operative Evaluation
of Patient and/or Follow-up
Phone Call

This category includes telephone call(s) to parents and some situation phone call(s) to the recipient's pediatrician and/or specialist to review medical history and obtain medical clearance.

CPT-4 Code	Definition
99358	Prolonged evaluation and management service before and/or after direct [face-to-face] patient care; first hour
99359	each additional 30 minutes (list separately in addition to code for prolonged service)

Portable Equipment
Assembly/Disassembly

This service is billed with CPT-4 code 99199 (unlisted special services, procedure or report) and with the following requirements:

- Physician must document start, stop and total time
- Reimbursement for this service is restricted to once per site per day
- Records certifying equipment testing and calibration by qualified personnel according to manufacturer's guidelines must be available upon request

Supplies

Dental anesthesia generally bills using surgical CPT-4 code 41899 (unlisted procedure, dentoalveolar structures). Supplies are billed with modifier UA/UB along with the appropriate surgical procedure code.

Modifier	Definition
UA	Medicaid level of care 10, as defined by each state. 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. 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: Syringes and needles are included in the reimbursement rate for all injectable drugs and are not separately reimbursable. IV fluid and IV tubing are to be billed with HCPCS code X7700.

Drugs

Drugs will be reimbursed by billing with the appropriate procedure code. Drugs without an acceptable procedure code can be billed with HCPCS code J3490 (unclassified drugs). Drugs that do not have a price on file must have an invoice attached to the claim. All drugs must be labeled with legible expiration dates and disposed of properly when indicated. All drugs must be stored and transported appropriately.

Post-Operative Care

When provided by the anesthesiologist, these services are to be billed with CPT-4 code 99199 (unlisted special services, procedure or report). Post-operative services are comparable to post-anesthesia care unit (PACU) services and include, but are not limited to, continuous pulse oximetry monitoring in the recovery area and monitoring of vital signs until ready to leave the office. Post-operative care services must all be documented on a PACU record, with admission, discharge and total time of service. A copy of the record must be attached to the claim form.

Non-Covered Services

This category includes, but is not limited to, transportation expenses, equipment maintenance and depreciation, and costs for assistants.

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* field (Box 80)/*Reserved for Local Use* field (Box 19) of the claim or as an attachment. For an example, refer to the *Anesthesia Billing Examples* section of this manual.

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 obstetrician are included in the reimbursement for the surgical or obstetrical procedure itself and are not separately reimbursable.

Elective Sterilization

Anesthesiologists billing for the anesthesia time associated with an elective sterilization procedure must bill with either CPT-4 code 00851 or 00921. See the *Sterilization* section in the appropriate Part 2 manual for sterilization *Consent Form* (PM 330) requirements.

**Tubal Ligations:
Vaginal Delivery**

A postpartum tubal ligation performed in connection with a vaginal delivery is considered a separate procedure. The anesthesia for the tubal ligation must be billed with CPT-4 code 00851 (anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; tubal ligation/transection).

Tubal Ligations: Cesarean Delivery	Anesthesiologist time billed for a tubal ligation performed during a cesarean section should include the tubal ligation anesthesia by adding one (1) additional anesthesia time unit to the anesthesia time units for the cesarean section procedure (CPT-4 code 01961 or 01968). For an example, refer to the <i>Anesthesia Billing Examples</i> section of this manual.
Hysterectomy	Anesthesiologists billing for the anesthesia time associated with a hysterectomy must provide a copy of the hysterectomy consent form, regardless of the CPT-4 procedure code billed. Codes that always require a hysterectomy consent form are 00846, 00848, 00944, 01962, 01963 and 01969. See the <i>Hysterectomy</i> section in the appropriate Part 2 manual for hysterectomy consent form requirements.
Procedures Billed Only for Diagnostic and Therapeutic Services	CPT-4 procedure codes 62267 – 62273, 62280 – 62287, 62290 – 62297, 62310, 62311, 62318, 62319, 64400 – 64439 and 64444 – 64530 are used only for billing injection, drainage or aspiration procedures for diagnostic or therapeutic services. Anesthesiologists performing these diagnostic and therapeutic services are acting as the primary surgeon and should bill these CPT-4 codes with modifier AG. These codes should not be billed with an anesthesia modifier.

Normal, Uncomplicated Anesthesia Modifiers

All anesthesia claims require a modifier. Failure to use the applicable modifier will result in the claim being returned to the provider for correction.

Modifier P1 must be billed with the appropriate five-digit CPT-4 anesthesia code to identify a normal, uncomplicated anesthesia provided by a physician.

Certified Registered Nurse Anesthetist (CRNA)

Refer to “Anesthesia Supervision” on a following page in this section for information about billing for Certified Registered Nurse Anesthetist (CRNA) services.

Multiple Modifiers

If more than one modifier is necessary, bill with modifier 99 (multiple modifiers) and list the appropriate modifiers in the *Remarks* field (Box 80)/*Reserved for Local Use* field (Box 19) of the claim.

Prone Position or Surgical Field Avoidance Modifier

Modifier 22 (increased procedural services) should be used only for anesthesia procedures with base units of three or less. These techniques are included in the anesthesia base units for codes with a base value greater than three.

Services Included In Basic Rate

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* field (Box 80)/*Reserved for Local Use* field (Box 19) of the claim or as an attachment.

**Separately Reimbursable
Anesthesia Services**

Medi-Cal separately reimburses for the following anesthesia services.

<u>CPT-4 Code</u>	<u>Definition</u>
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
62319	Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal) Note: Reimbursable only if the <i>Remarks</i> field (Box 80)/ <i>Reserved For Local Use</i> 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.
93503	Insertion and placement of flow directed catheter (for example, Swan-Ganz) for monitoring purposes

Anesthesiologist Present but not Administering Anesthesia

CPT-4 procedure codes 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 computed tomography (CT) 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* field (Box 80)/*Reserved for Local Use* field (Box 19) of the claim or on an attachment.

General Anesthesia Services Guidelines: Medical Necessity

General anesthesia services for procedures not ordinarily requiring anesthesia, or usually requiring only local infiltration, digital block or topical anesthesia, may be billed if medically necessary using the appropriate anesthesia modifiers.

Medical, Radiological, Surgical and Pathological Procedures

Documentation of the medical necessity is required in the *Remarks* field (Box 80)/*Reserved for Local Use* field (Box 19) of the claim.

Pelvic Examination Under Anesthesia

Pelvic examination under anesthesia is by definition an independent procedure. However, when it is carried out 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.

Epidural Opioid Administration

The intermittent or continuous administration of epidural opioids to treat severe chronic intractable pain of malignant or non-malignant origin is a Medi-Cal benefit, subject to prior authorization. An implantable infusion pump may be reimbursed when used to administer opioid drugs intrathecally or epidurally in patients with severe chronic intractable pain when the following criteria are met:

- Documentation that parenteral and/or oral administration of analgesia has been unsatisfactory in continuing to provide adequate analgesia for the patient
- Documentation that the patient's history indicates the patient did not respond to non-invasive methods of pain control such as attempts to eliminate the etiology of the pain and/or behavioral approaches to pain management
- A preliminary trial of intraspinal opioid administration should be first undertaken with a temporary intrathecal or epidural catheter to substantiate adequately acceptable pain relief and tolerable degree of side effects. This trial procedure may be performed during the same time period as the hospitalization for the implantation of the permanent catheter and reservoir/pump.

The test injection of opioid medication (usually morphine) may be billed using one of the following CPT-4 codes:

<u>CPT-4 Code</u>	<u>Definition</u>
62318	Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; cervical or thoracic
62319	lumbar, sacral (caudal)

Note: Reimbursable only if the *Remarks* field (Box 80)/*Reserved For Local Use* 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.

Hospitalization

Authorization is required for hospitalization for the implantable pump procedure. Catheter implantation, pump/reservoir implantation, removal of pump/reservoir, and electronic analysis of the programmable, implanted pump may be reimbursable with the following codes and appropriate modifiers

	<u>CPT-4 Code</u>	<u>Definition</u>
Catheter Implantation	62350	Implantation, revision or repositioning of tunneled intrathecal or epidural catheter, for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy
	62351	with laminectomy
	62355	Removal of previously implanted intrathecal or epidural catheter
Reservoir/Pump Implantation	62360	Implantation or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir
	62362	Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming
Removal of Reservoir or Pump	62365	Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion.
Electronic Analysis of Pump	62367	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming
	62368	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); with reprogramming

Infusion pumps are used for the controlled administration of opioids in pain management. Pumps may be worn externally by the patient or may be implanted subcutaneously. Both types of infusion pump may be attached to an implantable epidural or intrathecal catheter for administration of analgesia. External pumps may be used in some patients, especially if the expected duration of use is short. External infusion pumps may be reimbursable when billed with the following HCPCS codes.

External Infusion Pumps

<u>HCPCS Code</u>	<u>Definition</u>
E0779	Ambulatory infusion pump, mechanical, reusable, for infusion 8 hours or greater
E0780	Ambulatory infusion pump, mechanical, reusable, for infusion less than 8 hours

Note: Code E0779 will require authorization if the billed amount exceeds \$100.

Authorization is required for the implanted infusion pump or reservoir, billed with the following HCPCS codes. The hospital must have an exclusion to its Medi-Cal contract to permit separate billing using the outpatient claim format for the programmable, implanted pump.

E0781	Ambulatory infusion pump, single or multiple channels, electric or battery operated, with administrative equipment, worn by patient
E0783	Infusion pump system, implantable, programmable (includes components, for example, pump catheter, connectors, etc.)

The intraspinal replacement catheter used with the implantable pumps is billed with code E0785 (implantable intraspinal [epidural/intrathecal] catheter used with implantable infusion pump, replacement).

Daily inpatient hospital management of epidural or subarachnoid continuous drug administration should be billed with CPT-4 code 01996. Outpatient refilling and maintenance of the programmable, implanted pump is billed with CPT-4 codes 95990 and 95991. Electronic analysis of the programmable implanted pump for intrathecal or epidural drug infusion without reprogramming is billed with CPT-4 code 62367. If the pump is also reprogrammed, providers should use CPT-4 code 62368.

Outpatient refilling and maintenance of the external infusion pump is billed with CPT-4 code 96521 (refilling and maintenance of portable pump). Refilling and maintenance of older nonprogrammable implanted pumps may be billed with CPT-4 code 96522 (refilling and maintenance of implantable pump or reservoir). Authorization is not required for these codes. The refilling and maintenance will occur monthly to quarterly, depending on individual patient needs.

**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):

<u>Modifier</u>	<u>Definition</u>
UA	<p>Medicaid level of care 10, as defined by each state</p> <p>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.</p>
UB	<p>Medicaid level of care 11, as defined by each state</p> <p>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.</p>

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.

Billing Requirements

Modifiers UA and UB are mutually exclusive; therefore, only one modifier is allowed for each surgical procedure. To prevent claim denial, select the appropriate modifier based on the preceding description.

Duplicate Billing

Medi-Cal policy limits reimbursement of a surgical procedure with modifier UA or UB to one provider, for the same recipient and date of service. Second and subsequent claims billed for the same procedure with the same modifier UA or UB for the same date of service to the same recipient and submitted by the same or different provider(s) will be denied.

Modifiers UA or UB will not conflict with the use of other required modifiers. For example, modifier AG (primary surgeon) or 80 (assistant surgeon) may be used on separate lines with UA or UB on the same claim form.

**Services Performed
More Than Once on the
Same Day**

A surgical procedure with modifier UA or UB performed more than once on the same day on the same recipient by the same or different provider(s) requires additional documentation indicating that the service was performed more than once on the same day. This information may be attached to the claim or entered in the *Remarks* field (Box 80)/*Reserved for Local Use* field (Box 19) of the claim.

**Anesthesia Injection Codes
Not Separately Reimbursable**

Local or general anesthesia injections are not separately reimbursable if a claim was previously submitted with a surgical procedure and modifier UA or UB. If a local or general anesthetic is billed separately for the same recipient on the same date of service by the same or different provider, the claim will be reduced by the amount previously paid. For more information, refer to the *Supplies and Drugs* section of this manual.

**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.

**Anesthesia Risk/
Emergency Modifiers**

An additional charge may be warranted in cases where patients present for anesthesia with certain complications and/or emergency conditions. Identify such cases by adding the appropriate modifier to the five-digit CPT-4 anesthesia code and include documentation of the condition and the patient's American Society of Anesthesiology (ASA) Physical Status Class in the *Remarks area/Reserved For Local Use* field (Box 19) of the claim or attached to the paper claim.

ASA Physical Status Class 3	For a patient with severe systemic disease, ASA Physical Status Class 3 (for example, severe essential hypertension or severe chronic obstructive pulmonary disease), use modifier P3.
ASA Physical Status Class 4 Non-Emergency	For a patient with severe systemic disease that is a constant threat to life, ASA Physical Status Class 4 (for example, severe chronic congestive heart failure, chronic severe neutropenia, or unstable angina), use modifier P4.
ASA Physical Status Class 4 Emergency	For a patient in ASA Physical Status Class 4 who requires <u>emergency</u> surgery (for example, acute appendicitis with severe thrombocytopenia needing emergency operation), use modifier P4 with ET.
ASA Physical Status Class 5 Emergency	For a patient who is moribund and not expected to survive without the operation, ASA Physical Status Class 5, and requires <u>emergency</u> surgery, use modifier P5 with ET. additionally, providers must document "time in attendance."

Anesthesia Modifiers Chart

The chart below lists the ASA ranking of patient physical status and the modifiers and added unit values associated with the rankings. It also shows three special circumstance modifiers and their added units of value.

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-9-CM diagnosis code 995.89	5
Unusual position/field avoidance	22 Increased procedural services	1
Extracorporeal circulation	P4 with ICD-9-CM diagnosis code 998.89	10

Duplicate Billing Not Allowed

Medi-Cal policy prohibits payment for duplicate services and/or billings. The second and subsequent claims for anesthesia services billed for the same date of service, the same recipient and the same procedure submitted by the same or different providers will be denied with RAD code 328, "Another procedure with an anesthesia modifier has been previously paid for the same recipient on the same date of service."

**Anesthesia Pump Assembly
and Operation**

The assembly and operation of a pump with oxygenator or heat exchanger (CPT-4 codes 99190 – 99192) is not separately reimbursable by Medi-Cal. Payment for assembly and operation of such pumps by hospital technicians is included in the reimbursement to the hospital.

**Pulse Oximetry:
Anesthesia Guidelines**

CPT-4 code 94760 (non-invasive ear or pulse oximetry for oxygen saturation; single determination) is reimbursable only to physicians when no other services are billed for the same recipient, by the same provider on the same date of service.

Split Case 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.

Documentation Requirements

The following detailed documentation is required for both anesthesiologists to be paid for services rendered. (For an example of correct documentation, refer to *Figure 2* in the *Anesthesia Billing Examples* section of this manual.)

- 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. In the *Remarks* field (Box 80)/*Reserved for Local Use* field (Box 19) of the claim indicate this is an anesthesia split case.
- Include the following on the attachment to the claim form:

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)

Note: Providers billing codes other than CPT-4 code 01967 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). When billing CPT-4 code 01967, an anesthesia report is required for all claims for 20 units or more; additionally, providers must document “time in attendance.”

**Nasal Endoscopy:
General Anesthesia
Requirements**

General anesthesia may be reimbursable for nasal endoscopy (CPT-4 codes 31231 – 31237) when the anesthesia is necessary for children younger than age of 12 or for extremely anxious or uncooperative patients. Medical justification for the anesthesia must be entered in the *Remarks* field (Box 80)/*Reserved for Local Use* field (Box 19) of the claim or attached to the paper claim.

**Certified Registered
Nurse Anesthetist**

Article 7, Chapter 6, Division 2 of the *Business and Professions* (B&P) *Code*, states that it is unlawful for any person to hold himself or herself out as a nurse anesthetist without having been certified by the Board of Registered Nursing. There are no additional licensing and certification requirements in order for nurse anesthetists to participate in the Medi-Cal program.

Anesthesia Supervision

Please refer to the *Rates : Maximum Reimbursement* section of the appropriate Part 2 manual for information and requirements.

CRNA Modifiers

Physicians enter modifier QK on the claim with the procedure code when billing for supervision of a CRNA.

**CRNA Services With
Direct Physician Supervision**

CRNAs bill anesthesia services rendered with direct supervision of a physician with the appropriate five-digit CPT-4 anesthesia code and modifier QX in conjunction with the appropriate service modifier(s).

**CRNA Services Without
Direct Physician Supervision**

CRNAs bill anesthesia services rendered without direct supervision of a physician with the appropriate five-digit CPT-4 anesthesia code and modifier QZ in conjunction with the appropriate service modifier(s).

**Anesthesia Risk/
Emergency Modifiers**

CRNAs may be reimbursed for additional anesthesia patient risk factors or special circumstances. For this reimbursement, CRNAs must use modifier QX or QZ in conjunction with the appropriate service modifier(s) (listed in the “CRNA Anesthesia Modifiers Chart”). In addition, the CRNA must document the patient’s condition and list the American Society of Anesthesiology (ASA) Physical Status Rank in The *Remarks* field (Box 80)/*Reserved for Local Use* field (Box 19) of the claim.

**CRNA Anesthesia
Modifiers Chart**

The following chart lists the ASA ranking of a patient's physical status and the modifiers and added unit values associated with the rankings. It also shows three special circumstance modifiers and their added units of value.

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-9-CM code 995.89	5
Unusual position/field avoidance	22 and QX or QZ	1
Extracorporeal circulation	P4 and QX or QZ with ICD-9-CM code 998.89	10

Pain Management and
Emergency Services

The CRNA may provide selected pain management and emergency services both inside and outside the operating room. These services include endotracheal intubation (CPT-4 code 31500) and injection of somatic and sympathetic nerves with anesthetic agents (64400 – 64530). CRNAs must use modifier AG when billing with these codes.

Reimbursement for these procedures rendered by a CRNA is the same as that made to a physician.