

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

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## Anesthesia Billing Examples: CMS-1500

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Examples in this section are to assist providers in billing for Anesthesia services on the *CMS-1500* claim form. Examples are based on current Medi-Cal anesthesia policy. Refer to the *Anesthesia* section of this manual for detailed policy information. Refer to the *CMS-1500 Completion* section of this manual for instructions to complete claim fields not explained in the following examples. For additional claim preparation information, refer to the *Forms: Legibility and Completion Standards* section of this manual.

**Billing Tips:** When completing claims, do not enter the decimal points in ICD-9-CM codes or dollar amounts. If requested information does not fit neatly in the *Reserved for Local Use* field (Box 19) of the claim, type it on an 8½ x 11-inch sheet of paper and attach it to the claim.

**Tubal Ligation Performed During a C-Section**

*Figure 1. Tubal ligation performed during a cesarean section.*

*This is a sample only. Please adapt to your billing situation.*

In this example, CPT-4 code 01961 (general anesthesia for; cesarean delivery only) is billed with modifier P1 (representing normal, uncomplicated anesthesia) for the cesarean section. This code is entered in the *Procedures, Services or Supplies* field (Box 24D). Anesthesia services are rendered for 75 total minutes.

Time units are calculated in 15-minute increments: 75 minutes divided by 15 minutes is 5 units. Add the additional 1 anesthesia time unit for the tubal ligation (5 + 1) and enter the total (6) in the *Days or Units* field (Box 24G).

**Note:** No additional base units are added for the tubal ligation because this is considered an add-on procedure.

Enter the date of service, June 4, 2007, as 060407 in the *Date(s) of Service* field (Box 24A) and Place of Service code 21 (inpatient hospital) in Box 24B.

Enter the usual and customary charges in the *Charges* field (Box 24F).

19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? \$ CHARGES				
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										<input type="checkbox"/> YES <input type="checkbox"/> NO				
1. _____ 3. _____										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.				
2. _____ 4. _____										23. PRIOR AUTHORIZATION NUMBER				
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OF UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY		CPT/HCPCS	MODIFIER						
1	06	04	07			21	01961	P1		63000	6		NPI	
2													NPI	
3													NPI	
4													NPI	

*Figure 1. Tubal Ligation Performed During a Cesarean Section.*

**Add-on Codes**

*Figure 2. Add-on Codes*

*This is a sample only. Please adapt to your billing situation.*

In this example, the primary anesthesia procedure 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]) is billed with modifier P1 (representing normal, uncomplicated anesthesia) on the first line of the *Procedures, Services or Supplies* field (Box 24D).

CPT-4 code 01968 (anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia) is billed with modifier P1 as the add-on code, on the second line of the *Procedures, Services or Supplies* field (Box 24D). CPT-4 code 01968 with modifier P1 must be billed in conjunction with code 01967.

Time units are calculated in 15-minute increments.

**Note:** Start, stop and total times for code 01967 are documented along with the actual time in attendance on an attachment to the paper claim only if billing for 20 units or more. Times for code 01968 are documented on an attachment to the paper claim if billing for more than 40 units of time (10 hours). Enter time in military units.

Enter the usual and customary charges in the *Charges* field (Box 24F).

19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO		\$ CHARGES		
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										22. MEDICAID RESUBMISSION CODE		ORIGINAL REF. NO.		
1. _____ 3. _____										23. PRIOR AUTHORIZATION NUMBER				
2. _____ 4. _____														
24. A. DATE(S) OF SERVICE				B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY		CPT/HCPCS	MODIFIER						
1	06	04	07			21	01967	P1		20000	3		NPI	
2	06	04	07			21	01968	P1		30000	4		NPI	
3													NPI	
4													NPI	

I OR SUPPLIER INFORMATION

*Figure 2. Add-On Code Billing Example.*

**Split Case**

*Figure 3. Split case (a long procedure in which one anesthetist begins delivery of anesthesia and a subsequent anesthetist completes delivery of anesthesia).*

In this example, 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]) is billed twice (once for each anesthesiologist) with modifier P1 (normal, healthy patient). These codes are entered in the *Procedures, Services or Supplies* field (Box 24D). The total anesthesia time in attendance for both anesthesiologists is 170 minutes.

Time units are calculated in 15-minute increments. Dr. Smith's actual time in attendance is 45 minutes and Dr. Jones' time in attendance is 125 minutes. Dr. Smith bills 3 units (45 divided by 15). Dr. Jones bills 9 units (125 divided by 15 equals 8, with the addition of the five minute remaining time increment, rounds the units up to 9).

Enter the date of service, April 4, 2011, as 040411 in the *Date(s) of Service* field (Box 24A) and Place of Service code 21 (inpatient hospital) in Box 24B.

Because this claim is split-billed, the two anesthesiologists' NPI numbers are required in the *Rendering Provider ID Number* field (Box 24J).

**Note:** The provider who submits the claim also must enter billing provider information in the *Billing Provider Info and Phone Number* field (Box 33) and NPI in Box 33A.

The nine-digit ZIP code entered in this box must match the billing provider's nine-digit ZIP code on file for claims to be reimbursed correctly.

In addition, the *Reserved for Local Use* field (Box 19) of the claim indicates anesthesia split case and see attachment. For additional information, refer to "Split Case for Anesthesia Services" in the *Anesthesia* section of this manual.

Enter the usual and customary charges in the *Charges* field (Box 24F).

19. RESERVED FOR LOCAL USE <b>Anesthesia split case. See attachment.</b>										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO		\$ CHARGES			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										22. MEDICAID RESUBMISSION CODE		ORIGINAL REF. NO.			
1. _____ 3. _____										23. PRIOR AUTHORIZATION NUMBER					
2. _____ 4. _____															
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER										F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	04		04		11		21	01967		P1	20000		3	NPI	0123456789
2	04		04		11		21	01967		P1	30000		9	NPI	1234567890
3															
4															

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Figure 3. Split Case Billing Example.

**Multiple Anesthesia  
Modifier 99***Figure 4. Multiple anesthesia modifier 99.*

In this example a healthy patient is receiving surgery for hemorrhoidectomy. The surgeon has decided to perform the procedure with the patient in the prone jackknife position, which complicates the administration of the anesthesia. This allows the anesthesiologist to request additional anesthesiology reimbursement (represented on the claim by the modifiers).

CPT-4 code 00902 (anesthesia for anorectal procedure) and modifier 99 (multiple anesthesia modifiers) are entered in the *Procedures, Services or Supplies* field (Box 24D).

The multiple anesthesia modifier 99 is billed because two or more modifiers are necessary to identify the anesthesia services rendered. In this case modifier 99 equals billing of both modifiers P1 (anesthesia services for a normal, healthy patient) and 22 (increased procedural services).

In the *Reserved for Local Use* field (Box 19) or on an attachment to the claim, document that modifier 99 equals modifier P1 (anesthesia for a normal, healthy patient) plus modifier 22 (unusual position/field avoidance).

Also shown in Box 19 is the name of the procedure performed – hemorrhoidectomy. This information is not required but will facilitate claim processing.

Enter the ICD-9-CM code 455.1 (internal thrombosed hemorrhoids) in the *Diagnosis or Nature of Illness or Injury* field (Box 21). The diagnosis code is entered as 4551.

Enter the date of service, April 4, 2011, as 040411 in the *Date(s) of Service* field (Box 24A) and Place of Service code 22 (outpatient hospital) in Box 24B.

Anesthesia services are rendered for 1 hour (60 minutes). Time units are calculated in 15-minute increments: 60 divided by 15 is 4. Enter a 4 in the *Days or Units* field (Box 24G). Enter the usual and customary charges in the *Charges* field (Box 24F).

<div style="border: 1px solid black; display: inline-block; padding: 2px;">1500</div> <b>HEALTH INSURANCE CLAIM FORM</b> <small>APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05</small>											
PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>											
1. MEDICARE <input type="checkbox"/> MEDICAID <input checked="" type="checkbox"/> TRICARE CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>						1a. INSURED'S I.D. NUMBER (For Program in Item 1) <b>90000000A95001</b>					
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) <b>DOE JOHN</b>						3. PATIENT'S BIRTH DATE MM DD YY SEX <b>06 21 62 M</b> <input checked="" type="checkbox"/> <input type="checkbox"/>					
5. PATIENT'S ADDRESS (No., Street) <b>1234 MAIN STREET</b>						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					
CITY <b>ANYTOWN</b>			STATE <b>CA</b>			7. INSURED'S ADDRESS (No., Street)			8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		
ZIP CODE <b>95823</b>			TELEPHONE (Include Area Code) <b>(916) 555-5555</b>			9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)			10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
9a. OTHER INSURED'S POLICY OR GROUP NUMBER						11. INSURED'S POLICY GROUP OR FECA NUMBER					
9b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>						11a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					
9c. EMPLOYER'S NAME OR SCHOOL NAME						11b. EMPLOYER'S NAME OR SCHOOL NAME					
9d. INSURANCE PLAN NAME OR PROGRAM NAME						11c. INSURANCE PLAN NAME OR PROGRAM NAME					
<b>READ BACK OF FORM BEFORE COMPLETING &amp; SIGNING THIS FORM.</b>											
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.  SIGNED _____ DATE _____						13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.  SIGNED _____					
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY				15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS: GIVE FIRST DATE MM DD YY				16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY					
19. RESERVED FOR LOCAL USE <b>HEMORRHOIDECTOMY, 99=P1 + 22. P1=ANESTHESIA SERVICES, HEALTHY PATIENT. 22=UNUSUAL POSITION/FIELD AVOIDANCE.</b>						20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line) 1. <b>4551</b>						22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.					
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) MODIFIER E. DIAGNOSIS POINTER						23. PRIOR AUTHORIZATION NUMBER					
1 <b>04 04 11</b> <b>22</b> <b>00902</b> <b>99</b>						F. \$ CHARGES G. DAYS OR UNITS H. EPDIT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #					
2						<b>80000</b> <b>4</b>					
3						NPI					
4						NPI					
5						NPI					
6						NPI					
25. FEDERAL TAX I.D. NUMBER SSN EIN				26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (If 994, circle one below) <input type="checkbox"/> YES <input type="checkbox"/> NO			
28. TOTAL CHARGE \$ <b>80000</b>				29. AMOUNT PAID \$				30. BALANCE DUE \$ <b>80000</b>			
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)  SIGNED <i>Jane Doe</i> DATE <b>04/30/11</b>						32. SERVICE FACILITY LOCATION INFORMATION <b>DOWNTOWN HOSPITAL 102 FIRST STREET ANYTOWN CA 958235555</b>					
33. BILLING PROVIDER INFO & PH # <b>(916) 555-5555</b>						a. <b>0123456789</b> b.					
SIGNED _____ DATE _____						a. <b>1234567890</b> b.					
NUCC Instruction Manual available at: <a href="http://www.nucc.org">www.nucc.org</a>											
APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)											

Figure 4. Multiple Anesthesia Modifier 99.