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Changes for Anesthesia Claims Under 5010 Transaction Code Set

The ASA has received a number of questions regarding changes in reporting anesthesia services after the implementation of the 5010 transaction code set standards. The transaction code sets are mandated under the administrative simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA). The X12 Standards Organization develops the standards for the transaction code sets. Among many other functions, the transaction code sets determine how electronic claims are submitted to payers. Currently, version 4010 is in use. The latest version of these standards is referred to as the 5010 standards and all HIPAA covered entities will be required to transition to the 5010 by January 1, 2012. Several of the 5010 changes have raised concerns among members and are addressed here. Two major concerns have been brought to our attention.

1. New standards appear to require anesthesiologists to provide the surgical code in addition to the anesthesia code on claims. A few payers have indicated they will require anesthesia claims to include the surgical CPT code as well because the 5010 standards require it. **This is a misinterpretation of the standards.**

The ASA has confirmed with the X12 Committee that developed the 5010 standards that no such requirement exists. The new Loop 2300 HI Segment is the portion of the 5010 transaction in which an anesthesiologist would report the surgical code. According to the 5010 standards, the 2300 HI segment is required only when:

(1) Anesthesia services are being reported on the claim

AND

(2) The provider knows the surgical code

AND

(3) Knows the adjudication of the claim will depend on provision of the surgical code.

All three conditions must be true for this segment to be required. The capitalized "AND" is a logic operator that, together with other logic operators such as "OR" or "NOT" indicate relationships between multiple conditions that must either exist or not exist for a rule to be valid or required. The AND operator means that both conditions connected by the AND must be true for the rule to valid. The OR operator means that if either of the two conditions connected by the OR is true, the rule is valid. In this case there are three conditions connected by AND operators, so all three conditions must be true for the requirement to be valid. The X12 Standards Committee explains that it is not compliant with the guide to require anesthesiologists to submit surgical codes unless the provider knows those codes, but it appears that "the word has not gotten out to everyone."

Payers can, however, create a requirement for the surgical codes through contracts**. Physicians should review all contracts to confirm that they do not create requirements where none exist under the transaction code set standards.**

2. Payers are requiring additional information when physicians submit claims with anesthesia CPT codes containing "not elsewhere classified (NEC)" or "not otherwise specified (NOS)" in their descriptors. This may make sense for surgical codes because the CPT code set includes thousands of specific codes to describe almost every surgical procedure. The CPT includes the NEC/NOS codes for those few instances when a specific code does not exist. The intent is one code for one specific case.

Anesthesia CPT codes are constructed differently. The intent is that one anesthesia code is used to report anesthesia for many similar surgical cases. There are 52 anesthesia codes that include "not otherwise specified" in their descriptors to cover anesthesia for a range of surgical procedures that are similar in terms of location, technical difficulty and risk. Only one anesthesia code is truly not specific, 01999, and requires additional narrative description for all uses. The actual language in the standard indicates that the Description is required when the code is non-specific. However, use of phrases such as "not otherwise specified" does not make an anesthesia code non-specific.

The ASA is actively working with both X12 and payers to clarify how NOS is used differently in the anesthesia codes than for surgical codes. CMS representatives acknowledged that they are aware of this issue during a December 7, 2011 call on the 5010. **At this time, we cannot provide an estimate of a date when this matter will reach resolution, but will provide additional information when it becomes available.**

A much less significant change in the new standards is that anesthesiologists will no longer report anesthesia time in units, but instead will have to report time in minutes, just as they do now for Medicare claims. Payers can still pay based on time units by converting the number of anesthesia minutes to time units. This can be accomplished through contractual arrangements between payers and anesthesiologists. The ASA has previously addressed this issue, which may be found at: http://www.asahq.org/For-Members/Advocacy/Washington-Alerts/New-Regulation-Regarding-Reporting-of-Anesthesia-Time.aspx

As always, the ASA is available to provide information to members regarding these matters.