American Society of Anesthesiologists™

Timely Topics
Payment and Practice Management

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Anesthesia Payment Basics Series: #1 Codes and Modifiers

To properly and accurately report anesthesia services, one must know and adhere to rules and guidelines that are specific to anesthesia care. Additionally, the formula used to determine payment for anesthesia services is unique to anesthesia. These rules and formula may be misunderstood or improperly applied. This ASA Timely Topic is the first of a series that will break the components of anesthesia billing and payment down into individual components and provide explanation on what the components represent.

Codes and Modifiers

Any claim for a professional healthcare service must clearly communicate what service/procedure was performed and why is was done. To provide clarity and standardization, the Administrative Simplifications provisions within the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all covered entities to use specially designated code sets on claims for services.

Procedures and services are reported with codes and modifiers from the CPT® code set. CPT stands for Common Procedural Terminology and this code set is owned and maintained by the American Medical Association (AMA). Anesthesia codes – sometimes referred to as "ASA codes" are part of the CPT code set.

Examples of CPT codes applicable to anesthesia include:

CPT Code	Descriptor
00790	Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; not otherwise specified
01402	Anesthesia for total knee arthroplasty

As you can observe from these examples, some CPT Anesthesia codes are broad and encompass anesthesia care for a range of diagnostic or therapeutic services (eg, 00790) while others are more narrow and describe anesthesia care for limited and specific services (eg, 01402).

CPT Modifier 22 – *Increased Procedural Services* is an example of a CPT modifier that may be used with anesthesia codes. As explained in the ASA Relative Value Guide ® (RVG™), this modifier is used to report instances of field avoidance and the increased work and complexity that follows when an anesthesiologist has limited access to the patient's airway.

The Healthcare Common Procedure Coding System (HCPCS) includes codes and modifiers that may also be used to report services or drugs and supplies when appropriate. The HCPCS code set includes several modifiers that are specific to anesthesia care and are required on claims submitted to Medicare and many other payers.

HCPCS Modifier	Descriptor
AA	Anesthesia Services performed personally by the anesthesiologist
AD	Medical Supervision by a physician: more than 4 concurrent anesthesia procedures
QK	Medical Direction of two, three or four concurrent anesthesia procedures involving qualified individuals
QX	Qualified nonphysician anesthetist service: With medical direction by a physician
QY	Medical direction of one qualified nonphysician anesthetist by an anesthesiologist
QZ	CRNA service: Without medical direction by a physician
Source: Medicare Claims Processing Manual, Chapter 12, Sections 50I and 140.3.3 as of 6/11/2019	

Physician anesthesiologists report AA, AD, QK, or QY. A CRNA or Anesthesiologist Assistant reports QK; Modifier QZ is specific to CRNAs.

Payers may also require HCPCS modifiers to denote monitored anesthesia care (MAC):

HCPCS Modifier	Descriptor
QS	Monitored anesthesia care service
G8	Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedures
G9	Monitored anesthesia care for patient who has a history of server cardio-pulmonary condition
Source: Medicare Claims Processing Manual, Chapter 12, Sections 50I and 140.3.3 as of 6/11/2019	

ICD-10-CM codes are used to describe why a service or procedure was performed. If CPT/HCPCS predicate how much a physician or other qualified provider will be paid for a service, ICD-10-CM predicates if s/he will get paid as these codes establish medical necessity and are used to confirm whether the scenario in which the service was provided conforms with the payer's coverage policies.

Unlike CPT and HCPCS which run off a calendar year, the ICD-10-CM updates take effect at the beginning of a fiscal year which starts October 1. Also, unlike CPT, ICD-10-CM's instructions and guidelines on how to use the codes are part of the code set and must be followed by all covered entities. Since that is not the case with CPT, we can sometimes see some variation in payer instructions.

CMS and other payers create and use edits that set limitations on codes may be reported together or establish a cap on how many units of a service may be reported. CMS has created the National Correct Coding Initiative (NCCI) which is also used by a good many other payers. Review the both the manual and the edits and give special attention to Chapter 2 in the manual as that is specific to anesthesiology. The NCCI manual is updated annually and the edits themselves are updated quarterly.

CPT and HCPCS codes and modifiers describe a service and how it was performed. ICD-10-CM codes are used to show why a service was performed. The code sets are updated each year; use the editions that correspond to the date of service. It is important to understand how these codes are intended to be used so that claims are accurate, that they avoid abusive or fraudulent billing and that they result in prompt and correct payment for care provided.

Putting it together - Examples of coding based on the information in this article:

On February 21, 2019, Dr. A medically directs CRNA A in providing anesthesia care to a patient for removal of her gall bladder. This is one of three concurrent cases.

CPT Code
00790 - Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; not otherwise specified

HCPCS Modifiers
Dr A reports QK - Medical Direction of two, three or four concurrent anesthesia procedures involving qualified individuals
CRNA A reports the same CPT code with modifier QX - Qualified nonphysician anesthetist service: With medical direction by a physician

ICD-10-CM Code
K80.01 - Calculus of gallbladder with acute cholecystitis with obstruction

On June 1, 2019, Dr. B personally provides anesthesia care for a patient undergoing a total right knee replacement.

CPT Code
01402 - Anesthesia for total knee arthroplasty

HCPCS Modifier
AA - Anesthesia Services performed personally by the anesthesiologist

ICD-10-CM Code
M17.11 - Unilateral primary osteoarthritis, right knee