American Society of Anesthesiologists™

Timely Topics
Payment and Practice Management

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Anesthesia Payment Basics Series: #5 Qualifying Circumstances

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 fifth of a series that breaks the components of anesthesia billing and payment down into individual components and provides explanation on what the components represent.

Qualifying Circumstances

The previous article in this series provided information on ASA Physical Status. It covered the modifiers used to report the six classification levels and pointed the reader to where s/he could find more information on them. Please see https://www.asahq.org/standards-and-guidelines/asa-physical-status-classification-system to review those guidelines as last amended October 23, 2019 by the ASA House of Delegates.

Like Physical Status, the Centers for Medicare & Medicaid Services (CMS) does not recognize Qualifying Circumstances for additional payment, but many private payers do. According to our 2018 annual Commercial Conversion Factor survey, approximately 85% of payers covered Qualifying Circumstance codes. As such, it's important that this be considered in your contracts with private payers.

Unlike Physical Status, we use add-on codes rather than modifiers to convey these circumstances to payers on claims for anesthesia services. These add-on codes are included in the AMA's Current Procedural Terminology (CPT®) code set in the Medicine section but instructions on how to report them are found in CPT's Anesthesia Guidelines. The ASA Relative Value Guide ® (RVG™) also includes them and the 2020 edition provides the following introductory instructions:

> *Many anesthesia services are provided under particularly difficult circumstances depending on factors such as extraordinary condition of patient, notable operative conditions, unusual risk factors. This section includes a list of important qualifying circumstances that significantly impact the medical decision making and work intensity of the anesthetic service provided. These procedures would not be reported alone but would be reported as additional procedure numbers qualifying an anesthesia procedure or service*.

The code numbers, code descriptors and the base unit value assigned to each code (note, the base unit value is not part of the AMA's CPT code set) are:

+99100	Anesthesia for patient of extreme age, younger than 1 year and older than 70 (List separately in addition to code for primary anesthesia procedure)	1 Base Unit
+99116	Anesthesia complicated by utilization of total body hypothermia (List separately in addition to code for primary anesthesia procedure)	5 Base Units
+99135	Anesthesia complicated by utilization of controlled hypotension (List separately in addition to code for primary anesthesia procedure)	5 Base Units
+99140	Anesthesia complicated by emergency conditions (specify) (List separately in addition to code for primary anesthesia procedure	2 Base Units

Some points to keep in mind when reporting Qualifying Circumstances:

- When the anesthesia code is specific to pediatric patients, it may not be appropriate to report both the anesthesia code and code +99100. For example, if the anesthesia service provided is described with code 00326 – *Anesthesia for all procedures on the larynx and trachea in children younger than 1 year of age* – code +99100 should not also be reported.
- In the opinion of several former and current members of the ASA Committee on Economics (COE), the upper age for code +99100 applies to patients that are $\geq$ 70 years and one day on the date of the procedure, ie one day over their 70th birthday.
- Code +99116 and +99135 cover the intentional and possibly pharmacologic lowering of a patient's body temperature or blood pressure. For that reason, these codes are not reported with cardiac procedures performed with cardiopulmonary bypass when hypothermia or hypotension may be the result of being on bypass.
- A definition of emergency that justifies use of code +99140 is included in both the RVG and CPT: *An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part.*
- More than one qualifying circumstance code may be reported when clinical/patient conditions support their use.

Putting It Together

A patient covered by a private plan that includes coverage for Qualifying Circumstances and Physical Status undergoes the procedure as described by CPT code 27506 - *Open treatment of femoral shaft fracture, with or without external fixation, with insertion of intramedullary implant, with or without cerclage and/or locking screws* - under emergency conditions to repair an open (compound) fracture. Per the ASA CROSSWALK®, this anesthesia care may be described with anesthesia CPT code 01230 - *Anesthesia for open procedures involving upper two-thirds of femur; not otherwise specified* – which has 6 base units. We will assume anesthesia time of 139 minutes and that the payer uses a 15-minute time unit computing time out to one decimal point. The conversion factor is $72.00 per unit.

If the patient's Physical Status is ASA II and s/he is 72 years old, reporting may be as follows:

Anesthesia CPT Code 01230	6 base units
Anesthesia Time of 139 minutes	9.3 time units
Modifier P2	0 base units
Add-on code +99100	1 base unit
Add-on code +99140	2 base units

And payment to be calculated using the equation:

(Base Units+ Time Units+ Modifying Units) * Conversion Factor

(6 base units + 9.3 time units + 1 base unit + 2 base units) * $72.00 = $1,317.60

For more information, please refer to the ASA Relative Value Guide and the AMA's CPT code set.