

Anesthesia Billing Basics

Considerations Checklist

This resource provides general information on anesthesia billing and coding. Coding and reimbursement rules change regularly, therefore providers must remain vigilant as changes occur and new information and resources become available. Billing and coding requirements can vary depending on the insurance carrier (e.g., Medicare, Medicaid, private insurer). It is imperative that CRNAs, as all providers, bill for their services correctly. Because of the complexity, and the expansive and technical nature of coding for services and procedures, as well as the importance of correct billing, it is recommended that CRNAs consult with certified billing/coding experts for specific billing questions.

Billing Considerations

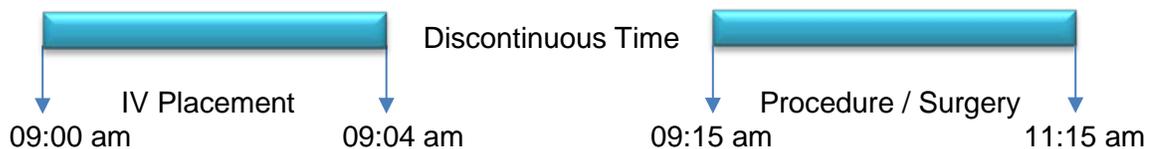
- For specific billing and coding questions, consult a certified billing/coding expert.
- For legal advice, consult an attorney in your state.
- Understand facility payer mix and payer guidelines for care delivery and documentation.
 - Review payer Local Coverage Determinations (LCDs).
- Additional research is typically required for the specific location/facility regarding payer reimbursement rates and coverage policies.
- Appropriate and accurate documentation is crucial to billing compliance, reimbursement, and any medical legal issues.
 - Educate facility practitioners and billing staff on proper anesthesia documentation.
 - If it's not documented, it did not happen.
 - Record all services provided.
 - Accurate documentation leads to increased billing compliance and maximized reimbursement.
- Identify quality improvement initiatives to promote compliance.
- If billing Medicare and submitting performance data for quality reporting programs it is essential to enroll, maintain, and update your billing and practice information.
 - The National Practitioner Identifier (NPI) is a unique identification number for covered health care providers. Covered health care providers and all health plans and health care clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. Individuals or organizations apply for the NPIs through the [CMS National Plan and Provider Enumeration System](#) website.
 - Medicare enrollment application via Provider Enrollment, Chain and Ownership System (PECOS) requires submission of information such as NPI, Tax Identification Number (TIN), professional information, provider specialty information, and practice location. Individuals or organizations enroll through the [CMS PECOS](#) website or [forms](#).

Anesthesia Time Definitions¹

- ❑ **Start Time:** When the anesthesia practitioner begins to physically prepare the patient for anesthesia services in the operating room or an equivalent area.
 - Does not include time spent with the patient during pre-anesthesia evaluation, as this is bundled into the base unit.
 - Does include start of IV, placing monitors, administration of pre-anesthesia sedation, or otherwise preparing the patient for anesthesia.

- ❑ **End Time:** When the anesthesia practitioner transfers care in the PACU to a qualified professional.
 - PACU time is billable until the patient may be placed safely under postanesthesia care.
 - If the time is extended in the PACU, it is billable but the anesthesia professional needs to document the circumstances of why they were with the patient longer than typically allowed.
 - Document time the patient is transferred to PACU staff (this is anesthesia end time).
 - Document vital signs until exit from OR.
 - Document final patient status when transferring patient care.

- ❑ **Discontinuous Time:** Document start and end time of block or line placement, which occur prior the primary anesthetic being given. Document induction time.



- ❑ **Relief:** Document start and stop times and the provider who is relieving another provider during the case.

- ❑ **Pre- and Post-Anesthetic Evaluation (after patient is released to PACU):** Not considered billable time and is not reported in anesthesia time calculation.

- ❑ **Cancelled Case / Evaluation and Management:** If the surgery was cancelled after the preoperative anesthesia evaluation or prior to induction, an anesthesiologist or non-medically directed CRNA *may* report an appropriate evaluation and management code for the service, only as long as the patient doesn't have surgery rescheduled and doesn't have surgery within the next 48 hours. The evaluation and management code is bundled within the 48-hour period.

If the case is cancelled after induction, the anesthesia professional may bill the full base unit and time associated with services up to that point and use a 53 modifier, as appropriate, to indicate that the procedure was discontinued.

The reason for case cancellation should be documented by the surgeon in the procedure or progress note and by the anesthesia professional in the anesthesia record.

- ❑ **Post-Operative Pain Management:** A block may be billed as a separate service/procedure if placed for post-operative pain management and is not the primary anesthetic technique. *Verify coverage with Medicare Administrative Contractor LCDs for specific requirements for coverage, coding, and documentation of post-operative pain management services.*
 - Applicable if the anesthesia for the surgical procedure was not dependent upon the efficacy of the regional block (e.g., epidural, spinal, peripheral nerve block).
 - Time spent on pre- or post-operative block placement is separated and not included in reported anesthetic time.
 - Surgeon request for post-operative pain management must be documented.
 - Documentation should also include the location, technique, medications, complications, and the performing provider.

Other considerations for anesthesia time:

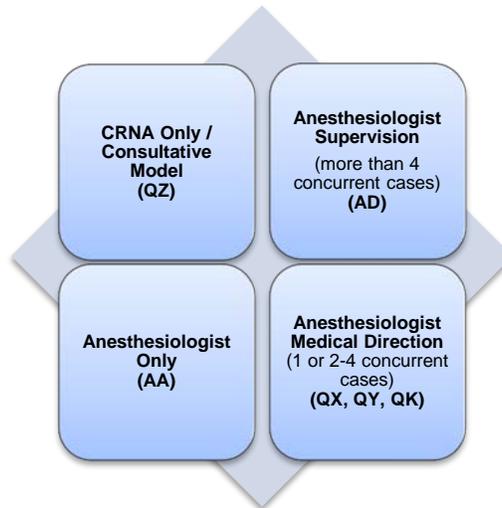
- ❑ Enter exact time, do not round.
- ❑ Use one consistent time piece.
- ❑ The end time for one case and start time for next case must be at least one minute apart.
- ❑ Clearly document names and start/stop times of any relief providers during the case.
- ❑ Local anesthesia is not billable if provided by a non-anesthesia provider
 - If an anesthesia provider is involved, it may be billed as anesthesia standby Monitored Anesthesia Care (*see next checkbox*)
- ❑ Anesthesia standby may be billable (e.g., anesthesia standby for a VBAC, in case a C-section becomes necessary).
 - Many payers do not pay for anesthesia standby time. Consult with individual payer documentation and requirements.

General documentation requirements

- ❑ Patient identifiers (name, date of birth, gender).
 - Ensure match to insurance card.
- ❑ Patient diagnosis.
 - Diagnosis for medical necessity, if applicable.
- ❑ Physical status.
- ❑ Service date.
- ❑ Service times.
 - Anesthesia start and end times.
 - Relief times.
- ❑ Service / procedure performed.
 - The procedure documented and billed for must match the surgeon's procedure dictated on his/her operative report. All providers must ask the surgeon at the end of each case what was performed.
- ❑ Type of anesthesia provided.
- ❑ Patient positioning.
- ❑ Discontinuous time.
- ❑ Relief anesthesia provider(s).
 - Document times when each anesthesia provider leaves or comes on to case.

- ❑ Surgeon request required for post-operative pain management.
- ❑ Post-operative pain management.
 - Start and stop times.
 - Location of block placement.
 - Type of regional anesthetic / peripheral nerve block.
 - Provider performing the procedure.
 - Record that block was for post-operative pain management per surgeon request.
- ❑ Facility name / OR number.
- ❑ Provider signature.
 - Each provider on the case must sign the record, including relief providers.
 - Must indicate if electronically signed.
 - Signature should be legible or name printed next to signature.
 - Anesthesia records cannot be pre-signed.

Practice Models



➤ [AANA Statement on the Most Cost-Effective and Safe Anesthesia Practice Models](#)

Practice Model Reimbursement^{1, 2}

Practice Model	Anesthesiologist Allowed	CRNA Allowed
CRNA only (No medical direction)	N/A	100%
Anesthesiologist only	100%	N/A
Medical direction	50%	50%
Payment at the medically supervised rate*	3 units (+ 1 unit for induction)	50%

* This is different from the CMS Part A Condition of Participation supervision requirement

Anesthesiologist Billing for Medical Direction vs. Billing at the Medically Supervised Rate^{1, 2}

Medicare pays for **medical direction** of CRNAs at 50% of the reimbursement for the case. To meet medical direction requirements of two to four concurrent cases, the anesthesiologist must meet the TEFRA rules. No more than 4 cases (CRNAs) can be medically directed at one time. An anesthesiologist must document the seven steps, which should be present in the anesthesia record. Two separate claims need to be filed for medically directed anesthesia procedures (one for the anesthesiologist and one for the CRNA).

1. Performs a pre-anesthetic examination and evaluation;
2. Prescribes the anesthesia plan;
3. Personally participates in the most demanding procedures in the anesthesia plan, including, if applicable, induction and emergence;
4. Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual;
5. Monitors the course of anesthesia administration at frequent intervals;
6. Remains physically present and available for immediate diagnosis and treatment of emergencies; and
7. Provides indicated-post-anesthesia care.

Billing at the medically supervised rate applies if circumstances result in more than 4 concurrent cases (CRNAs). An anesthesiologist may supervise more than 4 CRNAs concurrently. This billing method is rarely used because it does not allow for billing the full reimbursable amount (e.g., the anesthesiologist can only bill for 3 [or 4 if present for induction] base units).

Billing Calculation¹



**Contractual agreements may exist with insurance companies that specify payment of an agreed rate per unit. Adjust the calculation above to calculate the allowed amount. There may be a difference in billed amount and allowed amount.*

Anesthesia Claim Modifiers¹

Modifiers allow providers to denote additional information related to the procedure code. Every anesthesia claim billed to Medicare needs to include one of the following modifiers:

CRNA Modifiers	
QX*	CRNA service; with medical direction by a physician.
QZ	CRNA service; without medical direction by a physician.
Anesthesiologist Modifiers	
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 anesthetists.
QY	Medical direction of one qualified anesthetist by a physician.
GC	Services performed by a resident under the direction of a teaching physician.

**this modifier may also be used by other qualified non-physician anesthetists (e.g., anesthesiologist assistants)*

Other Modifiers*	Additional Billed Units
Physical Status P1,P2 or P6	+0 Units
Physical Status P3	+1 Unit
Physical Status P4	+2 Units
Physical Status P5	+3 Units
Age Less than 1 Year or Greater Than 70 Years	+1 Unit
Hypothermia	+5 Units
Hypotension	+5 Units
Emergency	+2 Units

**Many payers don't reimburse for these, payment varies by payer*

Monitored Anesthesia Care (MAC)

Monitored Anesthesia Care Modifiers	
QS	Monitored anesthesia care service. Anesthesia time must be reported.
G8	Monitored anesthesia care for deep complex complicated, or markedly invasive surgical procedures.
G9	Monitored anesthesia care for patient who has a history of severe cardio-pulmonary condition.

- If the patient loses consciousness or the ability to respond purposefully in any point of the case, the mode is considered a general anesthetic.**
- The provider of MAC must be qualified to administer anesthesia and be prepared to convert to a general anesthetic, if necessary.
 - See CFR §482.52(a).
- Verify MAC coverage with local Medicare Administrative Contractor policies as they may have specific requirements reimbursement.*

Reimbursement Denials

If a CRNA has received a reimbursement denial from a Medicare Administrative Contactor (MAC), a private health plan, or Medicaid, for services that are within CRNA state scope of practice, consider the following steps:

- ❑ Contact the MAC, private health plan, or the administrator of the Medicaid plan, which could be the state Medicaid program or a health plan, to speak with a representative to appeal the denial(s).
- ❑ Contact the state reimbursement specialist (SRS) to see if they are aware of the denials and if they already have a contact with the MAC, private health plan, or Medicaid plan as part of their SRS role.
- ❑ Gather and document pertinent information. Contact the AANA Federal Government Affairs with a summary of the denials, including:
 - What codes are being denied?
 - How long have these denials occurred?
 - What is the reason for the denials?
 - Do you have copies of the denials?
 - Have you tried to appeal the denials?
 - Have you been in contact with any representative issuing the denials? If so, please provide a summary of who you spoke with and what was said in these conversations?
- ❑ Supporting information on the high quality, cost effective care that CRNAs provide can be found on the [Public Relations Tools](#) website. (member login required)

Quality Reporting Requirements

For most recent information and tools related to the Medicare Assess & CHIP Reauthorization Act (MACRA)/Quality Payment Program and the Merit-based Incentive Payment System (MIPS) (formerly Physician Quality Reporting [PQRS]), visit AANA's [Quality and Reimbursement](#) website or contact the AANA Research and Quality Division.

Locum Tenens

- ❑ From a billing and reimbursement perspective, locum tenens only applies to physicians.
 - Payment may be made to the patient's regular physician for services of a locum tenens physician during the absence of the regular physician where the regular physician pays the locum tenens on a per diem or similar fee-for-time basis.³
- ❑ CRNAs working in temporary "locums" coverage arrangements need to be credentialed and privileged, obtain an NPI number, and bill for their own services.

AANA Contact

- ❑ Federal Government Affairs
info@aanadc.com
(202)484-8400
Topic area: billing and coding; claim denials
- ❑ State Government Affairs
sga@aana.com
(847) 655-1130
Topic area: state law; state scope of practice
- ❑ Professional Practice
practice@aana.com
(847) 655-8870
Topic area: scope of practice; practice management
- ❑ Research and Quality Division
research@aana.com
(847) 655-1170
Topic area: quality reporting

Resources

- [National Correct Coding Initiative Policy Manual for Medicare Services Chapter 2 Anesthesia Services](#)
- [Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners](#), see Section 50 for Anesthesiologist Services and 140 for CRNA Services
- [AANA Helpful CMS and Medicare Links*](#)
- [AANA Issue Brief on Reimbursement and Nurse Anesthesia*](#)
- [AANA Medicare Quality Reporting Essentials for CRNAs and Their Billing Office*](#)
- [AANA Statement on the Most Cost-Effective and Safe Anesthesia Practice Models](#)

*member login required

References

1. [Medicare Claims Processing Manual Chapter 12 - Physicians/Nonphysician Practitioners](#), see Section 50 for Anesthesiologist Services and 140 for CRNA Services
2. [Centers for Medicare & Medicaid Services \(CMS\). Payment for Moderate Sedation Services. Transmittal 3747, April 14, 2017.](#)
3. [Medicare Claims Processing Manual Chapter 1 - General Billing Requirements](#)

DISCLAIMER

This template is designed to be used as a guide for policy development. Each individual facility is responsible for and determines the level of detail and applicability. Identify any gaps between this template policy and your practice and carefully consider any unintended consequences. This information is provided as a service to our members and does not constitute legal advice. Federal, state, and local law and regulations should be consulted. Each individual utilizing this resource should consult with legal counsel in his or her state (or the State in which you intend to practice) to be properly advised on any laws or regulations governing his or her business practices.

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