



Billing and Reimbursement Policy: Anesthesia / General Anesthesia

Key coding, documentation and reimbursement points include:

- Charges should be billed on a CMS-1500.
- Valid anesthesia coding is required for the date and nature of service.
- Any billed anesthesia code must crosswalk with the surgical procedure performed. Supportive diagnosis coding is also required on the claim for the procedure performed.
- Services billed by anesthesia assistants and C.R.N. A.'s will not be reimbursed.
- Anesthesia start and stop times are required. Anesthesia start time is defined as the time the anesthesiologist begins the preparation of the patient. Anesthesia end time is defined as the time when the patient is placed under post-operative care.
- Anesthesia claims are paid based on the actual anesthesia time and the anesthesia relative value from the current year American Society of Anesthesiologists (ASA) guide. Anesthesia time intervals are 15 minutes per unit.
- Modifiers must be billed with anesthesia procedure codes to indicate whether the procedure was personally performed, medically directed or medically supervised.

Covered Required Modifiers Include:	
AA	Anesthesia services personally performed by anesthesiologist
AD	Medical supervision by a physician, more than four procedures
G8	Monitored anesthesia care
G9	Monitored anesthesia care
QS	Monitored anesthesia care
Non Covered Required Modifiers Include:	
QK	Medical direction of two, three or four concurrent anesthesia procedures
QX	C.R.N.A service, with medical direction
QY	Medical direction of one C.R.N.A by anesthesiologist
QZ	C.R.N.A service, without medical direction

- This policy applies to place of service 21, 22, 23 and 24.

Publication Date: 8/4/2011