

SECTION 12 ANESTHESIA

PROCEDURE CODES

MO HealthNet recognizes CPT anesthesia codes 00100 - 01999. The surgical procedure, for which anesthesia services are being provided, must be a covered MO HealthNet service.

When the anesthesiologist or CRNA administers anesthesia for multiple surgical procedures for the same participant on the same date of service during the same surgery, only the major procedure should be billed and the total number of minutes should be shown for all procedures.

Physicians and CRNAs may also bill for the insertion of intra-arterial lines, Swan Ganz catheters, central venous pressure lines, emergency intubation, and epidurals. These services are separately reportable when performed by the physician or CRNA using the following procedure codes and are subject to National Correct Coding Initiative (NCCI) editing.

20550	36420	36625	64400	64418	64449	64520
31500	36425	36660	64402	64420	64450	64530
36000	36510	36680	64405	64421	64479	93503
36010	36555	62273	64408	64425	64480	99100
36011	36556	62281	64410	64430	64483	99116
36014	36568	62282	64412	64435	64484	99135
36400	36569	62310	64413	64445	64505	99140
36405	36584	62311	64415	64446	64508	99148
36406	36600	62318	64416	64447	64510	99149
36410	36620	62319	64417	64448	64517	99150

CPT Code 01996 (daily hospital management of epidural or subarachnoid continuous drug administration) is billed with a quantity of 1 and without any modifier.

SUPERVISION (MEDICAL DIRECTION)

Anesthesiologists must have a provider specialty of anesthesiology to bill for medical direction of qualified and licensed Anesthesiologist Assistants (AA) and CRNAs.

Anesthesiologists must supervise at least two, but not more than four anesthetists. When the anesthesiologist and anesthetist both are involved in a single anesthesia service (supervision of only one anesthetist), the service is considered to be personally performed by the anesthesiologist. No separate payment is allowed for the CRNA and a charge for supervision is inappropriate.

MODIFIERS

The following modifiers should be used for anesthesia services.

- AA - Anesthesia services performed personally by anesthesiologist
- QK - Medical direction of two, three or four concurrent procedures involving qualified individuals
- QX – CRNA/AA service, with medical direction by physician
- QZ - CRNA service, without medical direction by physician

ANESTHESIA BILLING TIPS

- Administration of local infiltration, digital block, or topical anesthesia by the operating surgeon or obstetrician is included in the surgery fee, and a separate fee for administration should not be billed.
- Local anesthesia should not be reported separately. It is included in the procedure/surgery if provided in the physician's office; if provided in an Ambulatory Surgical Center (ASC) or outpatient department of the hospital, it is included in the facility charge; if provided on an inpatient basis, it is included in the accommodation revenue code for the facility.
- There may be an occasional need for anesthesia during CT scan or MRI services as a result of medically necessary circumstances, i.e., hyperactive child, mentally retarded individual, etc. To report this service, use procedure code 01922 (unlisted diagnostic radiologic procedure) with the appropriate modifier.
- Anesthesiologist monitoring telemetry in the operating room is non-covered.
- Routine resuscitation of newborn infants is included in the fee for the administration of the obstetrical anesthesia in low-risk patients.
- An AA and a CRNA are not allowed to bill for the same anesthesia services.
- Anesthesiologist and CRNA/AA services are not covered in the recovery room.
- Pain management is considered a part of postoperative care. However, if an epidural or intrathecal catheter is specifically inserted for pain management, it can be reimbursed. If already inserted for anesthesia, no separate payment is allowed.
- Many anesthesia services are provided under particularly difficult circumstances, depending on factors such as extraordinary condition of patient notable operative conditions, or unusual risk factors. These procedures may be reported in addition to anesthesia services. The following procedures should be billed:

99100 - Anesthesia for patient of extreme age, under one year and over seventy.

99116 - Anesthesia complicated by utilization of total body hypothermia.

99135 - Anesthesia complicated by utilization of controlled hypotension.

99140 - Anesthesia complicated by emergency conditions (specify).

When billing the above procedure codes, the maximum quantity is always "1" as reimbursement is based on a fixed maximum allowable amount.