Office of Workers' Compensation Programs (OWCP)
Anesthesia Service and Reimbursement Policy

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1.0 INTRODUCTION:

The U.S. Department of Labor's Office of Workers' Compensation Programs (OWCP), effective 12/5/2010, is implementing an Anesthesia Service and Reimbursement Policy. This policy was developed using the Anesthesia Guidelines and Payment for Anesthesiology Services issued by the Center of Medicare and Medicaid Service (CMS). The OWCP Fee Schedule has been modified to include an anesthesia service pricing structure. OWCP will use this policy and pricing structure for medical bill processing and payment reimbursement purposes of anesthesia services in accordance with the requirements and policies of Federal Medical Benefits established under the Federal Employees Compensation Act (FECA) and the Energy Employees Occupational Illness Compensation Program Act (EEOIC).

The responsibility for the content of the OWCP Anesthesia Service and Reimbursement Policy is with United States Department of Labor (USDOL) and no endorsement by the American Medical Association (AMA) is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable or related to any use, nonuse or interpretation of information contained in the OWCP Anesthesia Service and Reimbursement Policy. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of Current Procedural Terminology (CPT®), and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Any use of CPT® outside of the OWCP Anesthesia Service and Reimbursement Policy should refer to the most current Current Procedural Terminology which contains the complete and most current listing of CPT® codes and descriptive terms. Applicable Federal Acquisition Regulations (FAR) and Defense Federal Acquisition Regulations Supplement (DFARS) apply.

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OWCP's Anesthesia Service and Reimbursement Policy provides guidelines and requirements for payment, however, each physician or non-physician practitioner is limited to their scope of practice as defined under applicable State law and is not a guarantee for payment.

1.2   Access instructions to the OWCP Fee Schedule:

The link below is available to download or view the OWCP Fee Schedule from the DOL web-site. You must first read and accept the AMA "License for Use of "Current Procedural Terminology", Fourth Edition ("CPT®")".

https://www.dol.gov/owcp/regs/feeschedule/fee.htm

2.0   ANESTHESIA SERVICES AND OWCP PROCESSING REQUIREMENTS:

Anesthesia is the administration of a drug or gas to induce partial or complete loss of consciousness. Services involving administration of anesthesia should be reported by the use of the Current Procedural Terminology (CPT®) anesthesia five-digit procedure code plus modifier codes. Surgery codes are not appropriate.

2.1   Qualifications to Administer Anesthesia:

The organization of anesthesia services must be appropriate to the scope of services offered. OWCP requires that anesthesia services must be administered only by:

> (1) A qualified Anesthesiologist;
> (2) A doctor of medicine (MD) or osteopathy (DO) other than an Anesthesiologist;
> (3) A dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law;
> (4) A certified registered nurse anesthetist (CRNA), as defined in 42 CFR section 410.69, who is under the supervision of the operating practitioner or of an Anesthesiologist who is immediately available if needed; or
> (5) An Anesthesiologist's assistant as defined in 42 CFR section 410.69, who is under the supervision of an Anesthesiologist who is immediately available if needed.

2.1.1   Qualified Non-Physician Anesthetists:

A Certified Registered Nurse Anesthetist (CRNA) means a registered nurse who:

- Is licensed as a registered professional nurse anesthetist by the State in which the nurse practices;
- Meets any licensure requirements the State imposes with respect to non-physician anesthetists;
- Has graduated from a nurse anesthesia educational program that meets the standards of the Council on Accreditation of Nurse Anesthesia Programs; and
- Has passed a certification examination of the Council on Certification of Nurse Anesthetists or the Council or Recertification of Nurse Anesthetists;

An Anesthesiologist's assistant (AA) means a person who:

- Works under the direction of an Anesthesiologist;
- Is in compliance with all applicable requirements of State law, including any licensure requirements the State imposes on non-physician anesthetists; and
- Is a graduate of a medical school-based Anesthesiologist's assistant educational program (six year program) that is accredited by the Committee on Allied Health Education and Accreditation and includes 2 years of specialized basic science and clinical education in anesthesia at a level that builds on a premedical undergraduate science background

2.2   Anesthesia Modifiers:

Modifiers are two-digit indicators used to modify payment of a procedure code, assist in determining appropriate coverage or otherwise identify the detail on the bill. Every anesthesia procedure billed to OWCP must include one of the following anesthesia modifiers: AA, QY, QK, AD, QX or QZ. The other modifiers listed below may be used to identify specific situations in addition to the required modifiers.

Modifier	Description
AA	Anesthesia services personally performed by the Anesthesiologist
QY	Medical direction of one CRNA by an Anesthesiologist
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals
AD	Medical supervision by a physician, more than four concurrent anesthesia procedures
QX	CRNA service with medical direction by a physician
QZ	CRNA service without medical direction by a physician

2.2.1 Anesthesia Descriptive Modifiers:

A descriptive modifier is used to provide additional information about the anesthesia service and does not affect payment or reimbursement.

Modifier	Description
23	Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. The circumstance may be reported by adding modifier 23 to the procedure code of the basic service.
47	Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. This does not include local anesthesia.
QS	Monitored Anesthesia Care (MAC) services (can be billed by a CRNA or a physician)
G8	Monitored Anesthesia Care (MAC) for deep complex, complicated or markedly invasive surgical procedure
G9	Monitored Anesthesia Care (MAC) for patient who has history of severe cardiopulmonary condition
GC	Service performed in part by a resident under the direction of a teaching physician
P1	A normal healthy patient
P2	A patient with mild systemic disease
P3	A patient with severe systemic disease
P4	A patient with severe systemic disease that is a constant threat to life
P5	A moribund patient who is not expected to survive without the operation
P6	A declared brain-dead patient whose organs are being removed for donor purposes

Modifiers should be entered in item 24D following the procedure code on the OWCP-1500 claim form or electronic equivalent.

OWCP-1500 Example:

2.3 Supporting Documentation:

When billing anesthetic procedure code(s) and/or modifier(s) that by definition require supporting documentation that documentation must be included with bill submission.

3.0   OWCP REIMBURSEMENT CONDITIONS FOR ANESTHESIA SERVICES:

OWCP will reimburse anesthesia services provided by a qualified Anesthesiologist, physician, Certified Registered Nurse Anesthetist (CRNA) or an Anesthesiologist's Assistant (AA) that are related to the condition(s) accepted by the OWCP as work related.

For the purposes of this policy, the terms Anesthesiologist and physician may be used interchangeably since "physician" is a broader term and "Anesthesiologist" refers to the physician's medical specialty.   OWCP reimbursement for anesthesia services to physicians other than anesthesiologists is limited to the physician's scope of practice under applicable State law.

Also, within this policy "anesthetist" refers to a non-physician practitioner and may refer to either an Anesthesiologist's assistant (AA) and a certified registered nurse anesthetist (CRNA).   OWCP reimbursement for anesthesia services by a qualified non-physician anesthetist is limited to the practitioner's scope of practice under applicable State law.

OWCP provides reimbursement for the following:

> 1. Personally performed anesthesia services by the Anesthesiologist, physician, or CRNA.
> 2. Medically directed anesthesia services, in which both the Anesthesiologist and the anesthetist would bill OWCP separately for their component of the procedure using the appropriate anesthesia modifier.
> 3. Medically supervised anesthesia services by the Anesthesiologist.
> 4. Teaching services provided by the Anesthesiologist or a CRNA.

3.1   Personally Performed Anesthesia Services by an Anesthesiologist, Requirements, and Modifier Usage:

The OWCP allows reimbursement for personally performed anesthesia services by an Anesthesiologist when:

1   The Anesthesiologist is continuously involved in a **single case**. The Anesthesiologist must remain physically present in the operating room during the entire procedure when billing for personally performed physician services (modifier AA). If the Anesthesiologist is **not** continuously involved with the single case, another appropriate modifier as referenced in subsection 2.2 should be utilized.

2   The Anesthesiologist is involved in the training of physician residents in a single anesthesia case, two concurrent anesthesia cases involving residents or a single anesthesia case involving a resident that is concurrent to another case paid under

the medical direction rules. The Anesthesiologist must meet the teaching physician criteria defined in the Department of Health & Human Services (DHHS) CMS Internet Only Manual (IOM) Pub. 100-04, Chapter 12, Section 100.1.2(4) and 100.1.4.

3   The Anesthesiologist is continuously involved in a single case involving a student nurse anesthetist.

4   The Anesthesiologist and the anesthetist are involved in one anesthesia case and the services of each are found to be medically necessary. Documentation must be submitted by both the Anesthesiologist and the anesthetist to support reimbursement of the full fee amounts billed separately

3.2   Personally Performed Anesthesia Services by Certified Registered Nurse Anesthetist Requirements and Modifier Usage:

The OWCP provides reimbursement to qualified CRNA's for personally performed anesthesia services and may bill directly for their services or have payment made to an employer or an entity under which they have a contract. This could be a hospital, physician, group practice or Ambulatory Surgical Center (ASC).

All claims for personally performed anesthesia services furnished by qualified CRNA must indicate:

- The duration of the procedure in minutes – the amount of time elapsed from the preparation of the patient for induction to the moment when the anesthetist was no longer in attendance.
- The use of modifier QZ indicating the anesthesia service was provided without medical direction.
- If an Anesthesiologist or other physician (except the surgeon) functioning as an Anesthesiologist medically directed the anesthesia service the CRNA may not bill using modifier QZ. Instead the CRNA must use modifier QX to indicate anesthesia services were medically directed and the Anesthesiologist would submit a separate bill for medically directed anesthesia services.

QX	CRNA services with medical direction by a physician
QZ	CRNA service without medical direction by a physician
QS	*Monitored Anesthesia Care (MAC) services (can be billed by a CRNA or a physician)*

3.3   Medically Directed Anesthesia Services, Requirements, Modifier Usage and Reimbursement:

For a single anesthesia case involving the service of an Anesthesiologist and the service of the medically directed anesthetist, the reimbursement amount for each service may be no greater than 50 percent of the allowance. The total payment for both may not exceed

the total allowable amount that would be paid had the service been furnished solely by the Anesthesiologist.

When billing OWCP for the single medically directed service, the physician should use the modifier QY and the anesthetist should use the modifier QX.

Medical direction also occurs if the physician medically directs qualified individuals in two, three or four concurrent cases and the physician performs the following activities:

- Performs a pre-anesthetic examination and evaluation.
- Prescribes the anesthesia plan.
- Personally participates only in the most demanding procedures of the anesthesia plan, including, if applicable, induction and emergence.
- Ensures that any procedures in the anesthesia plan that the physician does not perform are performed by a qualified anesthetist.
- Monitors the course of anesthesia administration at frequent intervals.
- Remains physically present and available for immediate diagnosis and treatment of emergencies.
- Provides indicated post-anesthesia care.

Note: For medical direction, the physician must document in the medical record that he performed the pre-anesthetic exam and evaluation, provided indicated post-anesthesia care, was present during some portion of the anesthesia monitoring, and was present during the most demanding procedures, including induction and emergence, where indicated.

The physician can medically direct two, three or four concurrent procedures involving qualified individuals, all of whom could be CRNAs, AAs, interns, residents or combinations of these individuals. The medical direction rules apply to cases involving student nurse anesthetists if the physician directs two concurrent cases, each of which involves a student nurse anesthetist, or the physician directs one case involving a student nurse anesthetist and another involving a CRNA, AA, intern or resident.

Two separate bills must be filed for the medically directed anesthesia procedure—one for the Anesthesiologist and one for the anesthetist. Medical direction can occur in several different scenarios. When billing for the anesthesia services, please refer to the following examples for appropriate modifier usage:

- An Anesthesiologist is medically directing one anesthetist. The Anesthesiologist must submit the bill for anesthesia service using modifier QY and the anesthetist must bill separately using modifier QX. The OWCP payment would be split equally between the two providers with each provider receiving 50 percent of the OWCP allowable amount for the procedure.
- An Anesthesiologist is medically directing two, three or four qualified individuals. The Anesthesiologist must submit the bill for anesthesia services using modifier QK and the anesthetist must bill separately using modifier QX.

The OWCP payment would be split equally between the two providers with each provider receiving 50 percent of the OWCP allowable amount for the procedure.

If the anesthetist is qualified to perform anesthesia services without an Anesthesiologist, the anesthetist may submit a bill with modifier QZ indicating the service was performed without medical direction by a physician.

3.3.1 Definition of Concurrent Medically Directed Anesthesia Procedures:

Concurrency is defined with regard to the maximum number of procedures the Anesthesiologist is medically directing within the context of a single procedure and whether these other procedures overlap each other. **Concurrency is not dependent on the requirement that each of the cases involve an OWCP patient**. If an Anesthesiologist directs three concurrent procedures, two of which involve non-OWCP patients, and the remaining is an OWCP patient, OWCP considers these three concurrent anesthesia procedures, in which the anesthesiologists is required to bill OWCP with modifier QK.

3.3 2 Understanding the Determination of Concurrent Medically Directed Anesthesia Procedures:

The following example illustrates a concurrent medically directed anesthesia service and assists the Anesthesiologist in determining how many procedures they are directing during the OWCP case.

Example: Procedures A through E are medically directed procedures by an Anesthesiologist involving qualified anesthetists, of which procedure C is the OWCP case. The starting and ending times for each procedure represent the periods during which "anesthesia time" is counted.

Procedure A	Begins at 8 a.m. and lasts until 8:20 a.m.
Procedure B	Begins at 8:10 a.m. and lasts until 8:45 a.m.
Procedure C (OWCP case)	Begins at 8:30 a.m. and lasts until 9:15 a.m.
Procedure D	Begins at 9 a.m. and lasts until noon.
Procedure E	Begins at 9:10 a.m. and lasts until 9:55 a.m.

Procedure	Number of Concurrent Medically Directed Procedures
A	2
B	2
C	3
D	3

E	3

From 8:30–9:15 a.m., the length of procedure C involving the OWCP patient, the Anesthesiologist medically directed three concurrent procedures. From 8:30–8:45 a.m., the Anesthesiologist medically directed procedures B and C; from 8:45–9 a.m., the Anesthesiologist medically directed procedure C; from 9–9:10 a.m., the Anesthesiologist medically directed procedures C and D; from 9:10–9:15 a.m., the Anesthesiologist medically directed procedures C, D and E. Thus, during procedure C (OWCP patient), the Anesthesiologist medically directed three procedures at most. Using this example, the Anesthesiologist is required to submit the bill for anesthesia service using modifier QK indicating medical direction of two, three or four concurrent anesthesia procedures.

The same analysis shows that during procedure A or B, the Anesthesiologist medically directed two procedures; during procedure D or E, the Anesthesiologist medically directed three concurrent procedures at most.

A physician who is concurrently directing the administration of anesthesia to not more than four surgical patients cannot ordinarily be involved in furnishing additional services to other patients. However, addressing an emergency of short duration in the immediate area, administering an epidural or caudal anesthetic to ease labor pain, or periodic, rather than continuous, monitoring of an obstetrical patient does not substantially diminish the scope of control exercised by the physician in directing the administration of anesthesia to surgical patients. It does not constitute a separate service for the purpose of determining whether the medical direction criteria are met. Further, while directing concurrent anesthesia procedures, a physician may receive patients entering the operating suite for the next surgery, check or discharge patients in the recovery room, or handle scheduling matters without affecting OWCP reimbursement.

However, if the physician leaves the immediate area of the operating suite for other than short durations or devotes extensive time to an emergency case or is otherwise not available to respond to the immediate needs of the surgical patients, the physician's services to the surgical patients are supervisory in nature and not reimbursed by OWCP.

3.4 Medically Supervised Anesthesia Services:

OWCP considers medically supervised anesthesia services as those where the physician is directing more than four (4) concurrent anesthesia procedures.   When this occurs, the physician must bill the anesthesia service as medically supervised as opposed to medically directed anesthesia service. The physician must submit the bill for anesthesia services using modifier AD and the anesthetist will bill OWCP separately using modifier QX. The OWCP reimbursement to the anesthetist would be 50 percent of the OWCP allowable amount for the procedure.

Reimbursement to the supervising physician will be based on three (3) base units per anesthesia service when the physician is involved in furnishing medical supervision or is performing other services while directing concurrent procedures. An additional time unit

can be recognized if the physician can document he was present at induction. Supporting documentation not included during bill submission may affect reimbursement.

3.5 Teaching Services Provided by an Anesthesiologist:

Reimbursement for anesthesia teaching services may be made under the OWCP fee schedule at the maximum allowable if the teaching Anesthesiologist is involved in the training of a resident in a single OWCP anesthesia case, two concurrent anesthesia cases involving residents, of which one is an OWCP case, or a single OWCP anesthesia case involving a resident that is concurrent to another case paid under the medical direction rules.

To qualify for reimbursement, the teaching Anesthesiologist, or different physician in the same anesthesia group, must be present during all critical or key portions of the anesthesia service or procedure involved. The teaching Anesthesiologist (or another Anesthesiologist with whom the teaching physician has entered into an arrangement) must be immediately available to furnish anesthesia services during the entire procedure. The documentation in the patient's medical records must indicate the teaching Anesthesiologist's presence during all critical or key portions of the anesthesia procedure and the immediate availability of another teaching Anesthesiologist as necessary.

If different teaching anesthesiologists are present with the resident during the key or critical periods of the resident case, the ACS provider number of the teaching physician who started the case must be indicated in the appropriate field on the claim form or electronic equivalent.

3.5.1 Teaching Modifier:

GC	This service has been performed in part by a resident under the direction of a teaching physician

The teaching physician may bill OWCP for the amount of time present with the resident **if** he/she is present throughout the entire anesthesia period. The teaching physician must be present during all critical or key portions of the procedure. The Anesthesiologist or physician will bill OWCP using modifier AA and modifier GC to report such cases and must document their involvement in cases with residents. The documentation must be sufficient to support the payment of the personally performed anesthesia service and be available for review prior to initiating reimbursement. The teaching physician's presence **only** during the preparation of the patient before surgery and the observation of the patient after surgery, are <u>not</u> considered to be services that can be billed to OWCP.

Examples:

If the teaching physician is an Anesthesiologist and is involved in a single OWCP anesthesia procedure with one resident, the teaching physician should bill his services

with modifiers AA and GC.

By submitting the modifier GC, the teaching Anesthesiologist is indicating he was present during all critical or key portions of a single anesthesia procedure or concurrent anesthesia procedure.

If the teaching physician is involved in two concurrent anesthesia cases with two residents, one of which is an OWCP case, the teaching physician may bill OWCP the usual base units and anesthesia time for the amount of time he/she is present with the resident. The teaching physician should bill OWCP the anesthesia services using the payment modifier AA first followed by modifier GC.

3.6   Teaching Services provided by a CRNA:

Reimbursement can be made to a teaching CRNA who supervises a single case involving a student nurse anesthetist when the CRNA is continuously present. The CRNA must report the service using the modifier QZ, which designates that the teaching CRNA is not medically directed by an Anesthesiologist.

No reimbursement will be made by OWCP for the service provided by a student nurse anesthetist.

The American Association of Nurse Anesthetists' (AANA) standards for approved nurse anesthetist training programs allow teaching CRNAs to supervise two concurrent cases involving student nurse anesthetists. While the teaching CRNA can decide how to allocate time to optimize patient care in the two cases based on complexity of the anesthesia case, the experience and skills of the student nurse anesthetist, the patient's health and other factors, the CRNA must not be involved in other anesthesia cases when supervising two concurrent student nurse anesthetist cases. OWCP will allow reimbursement when a teaching CRNA is involved with two student nurse anesthetists and one of which is for an OWCP case:

- To bill the base units for the OWCP case, the teaching CRNA must be present with the student during the pre- and post-anesthesia care.
- Time units are recognized as the actual time the teaching CRNA is personally present with the student nurse anesthetist. The anesthesia time may be discontinuous.
- The teaching CRNA must document involvement in cases with student nurse anesthetists.
- The documentation must be sufficient to support the payment of the fee and be available for review upon request.
- The teaching CRNA must report these cases with modifier QZ.

3.7 Other Reimbursement Requirements:

The OWCP provides requirements and guidelines for other anesthesia services and those situations that may affect reimbursed.

3.7.1 Additional CRNA Reimbursement:

Reimbursement can be made for medical or surgical services furnished by non-medically directed qualified CRNA's if they are allowed to furnish these services under state law. These services may include the insertion of the Swan-Ganz catheters, central venous pressure lines, intra-arterial lines, pain management, emergency intubation and the pre-anesthetic examination and evaluation of a patient who does not undergo surgery. Reimbursement is determined under the OWCP medical fee schedule on the basis of the anesthesia fee schedule conversion factor, the geographic adjustment factor and the resource-based relative value units for the medical or surgical service.

Anesthesia services are assigned the same base units for physician anesthesia services using the OWCP Uniform Medical Plan; Anesthesia Fee Schedule effective July 1, 2022.

3.7.2 Group Practice:

If Anesthesiologists are in a group practice, one physician member may provide the pre-anesthesia examination and evaluation while another fulfills the other criteria. Also, one physician member of the group may provide post-anesthesia care while another member of the group furnishes the other component parts of the anesthesia service. However, the medical record must indicate that the physicians furnished the services and identify the physicians who rendered them.

3.7.3 Unusual Circumstances – Anesthesiologist and Anesthetist:

In **unusual circumstances**, when it is medically necessary for both the Anesthesiologist and the anesthetist to be completely and fully involved during a procedure, full reimbursement for the services of each provider is allowed. Each provider must submit documentation to support payment of the full fee. The physician would bill OWCP using modifier AA and the anesthetist would bill OWCP using modifier QZ as referenced in section 2.2

3.7.4 One Procedure – Two Anesthesiologists or Two Anesthetists:

When the first Anesthesiologist or the first anesthetist starts an anesthesia procedure and has to leave the patient to start another anesthesia procedure, and the procedure is then taken over by a second Anesthesiologist or a second anesthetist who then finishes the procedure, a bill should be submitted for reimbursement by the Anesthesiologist or anesthetist who spent the longest length of time with the patient. The amount of time reported on the OWCP bill should be the combined total time period of the procedure. Documentation should include the time spent with the patient for both the first and

second Anesthesiologist and/or CRNA.

Example:

- The first Anesthesiologist or anesthetist spent 15 minutes with the patient.
- The second Anesthesiologist or anesthetist spent 45 minutes with the patient.
- The bill would be submitted by the second Anesthesiologist or anesthetist for 60 minutes indicating the entire time period of the procedure.

4.0   MONITORED ANESTHESIA CARE (MAC):

The OWCP recognizes with advances in modern medical technology, there has been a shift in supplying some surgical and diagnostic services to an ambulatory, outpatient or office setting. Accompanying this, there has been a change in the provision of anesthesia services from the traditional general anesthetic to a combination of anxiolytic, hypnotic, amnestic and analgesic drugs. This section provides reimbursement requirements and guidelines for such services.

4.1   Description:

Monitored Anesthesia Care (MAC) is a specific anesthesia service for a diagnostic or therapeutic procedure. Indications for monitored anesthesia care include the nature of the procedure, the patient's clinical condition and/or the potential need to convert to a general or regional anesthetic.

4.2   MAC Modifier:

The use of the MAC modifier QS does not affect payment or reimbursement of service. It is used for informational purposes however; it must accompany the anesthesia service modifier if MAC service(s) were delivered and it will follow the modifier that indicates who provided the service. Example… AA QS

4.3   Indications and Limitations of Coverage and/or Medical Necessity:

1   In keeping with the American Society of Anesthesiologists' standards for monitoring, MAC should be provided by qualified anesthesia personnel in accordance with individual state licensure.   These individuals must be continuously present to monitor the patient and provide anesthesia care.

2   During MAC, the patient's oxygenation, ventilation, circulation and temperature should be evaluated by whatever methods are deemed most suitable by the attending anesthetist.   It is anticipated that newer methods of non-invasive monitoring such as pulse oximetry and capnography will be frequently relied upon. Close monitoring is necessary to anticipate the need for general anesthesia administration or for the treatment of adverse physiologic reactions such as hypotension, excessive pain, difficulty breathing, arrhythmias, adverse drug

reactions, etc. In addition, the possibility that the surgical procedure may become more extensive, and/or result in unforeseen complications, requires comprehensive monitoring and/or anesthetic intervention.

3   The following requirements for this type of anesthesia should be the same as for general anesthesia with regard to:

- The performance of pre-anesthetic examination and evaluation.
- The prescription of the anesthesia care required.
- The completion of an anesthesia record.
- The administration of necessary medications and the provision of indicated postoperative anesthesia care.

4   Appropriate documentation must be available to reflect pre- and post-anesthetic evaluations and intra-operative monitoring.

5   The MAC service rendered must be reasonable, appropriate and medically necessary.

6   MAC may be necessary for these active and serious accompanying situations or conditions to ensure smooth anesthesia (and surgery) by the prevention of adverse physiologic complications. The use of anesthesia modifiers, when the CPT code is not fully descriptive, is required as follows:

- G8 Anesthesia Modifier – used to indicate certain deep, complex, complicated or markedly invasive surgical procedures. This modifier is to be applied to the following anesthesia codes only: $00100^{©}$, $00300^{©}$, $00400^{©}$, $00160^{©}$, $00532^{©}$ and $00920^{©}$.
- G9 Anesthesia Modifier – represents "a history of severe cardiopulmonary disease," and should be utilized whenever the proceduralist feels the need for MAC due to a history of advanced cardiopulmonary disease. The documentation of this clinical decision making process and the need for additional monitoring must be clearly documented in the medical record.
- Anesthesia codes utilized to indicate the clinical condition of the patient receiving MAC:
  - ☐ **P1** – Healthy individual with minimal anesthesia risk
  - ☐ **P2** – Mild systemic disease
  - ☐ **P3** – Severe systemic disease with intermittent threat of morbidity or mortality
  - ☐ **P4** – Severe systemic illness with ongoing threat of morbidity or mortality
  - ☐ **P5** – Pre-morbid condition with high risk of demise unless procedural intervention is performed

Special conditions and/or criteria must be supported by documentation in the medical record.

7   Reimbursement for MAC will be the same amount allowed for full general anesthesia services if all the requirements listed under these indications are met. The provision of quality MAC is mandatory and requires the same expertise and the same effort (work) as required in the delivery of a general anesthetic. If the requirements are not fulfilled or the procedures are unnecessary, reimbursement will be denied in full.

8   For procedures that do not usually require anesthesia services, MAC

could be covered when the patient's condition requires the presence of qualified anesthesia personnel to perform monitored anesthesia in addition to the physician performing the procedure, and is so documented in the patient's medical record.

5.0   OWCP ANESTHESIA SERVICE PRICING FORMULA:

The OWCP allowance for anesthesia services is based on the following formula:

(Time Units + Base Units) x Conversion Factor = Allowance

5.1 Time Units:

Anesthesia time begins when the Anesthesiologist starts to prepare the patient for the procedure. Normally, this service takes place in the operating room, but in some cases, preparation may begin in another location (i.e., holding area). Anesthesia time is a continuous time period, in minutes, from the start of anesthesia to the end of an anesthesia service. In counting anesthesia time, the anesthesia practitioner can add blocks of time around an interruption in anesthesia time as long as the anesthesia practitioner is furnishing continuous anesthesia care within the time periods around the interruption.

OWCP will assign one (1) time unit when the total anesthesia time is equal to or less than 15-minutes. When calculating time units beyond the first 15 minutes, OWCP will utilize the rule of significant figures for rounding off to the closest whole number. Tenths of units from zero to four are rounded to zero; tenths from 5 to 9 are rounded up to the next whole number. This policy requires reporting of actual minutes spent from the time the Anesthesiologist or CRNA begins to prepare the patient for induction and ending when the patient is safely placed under post-operative supervision and the Anesthesiologist or CRNA is no longer in personal attendance. Time units will be calculated from the number of anesthesia minutes reported in locator 24G of the OWCP-1500 form or electronic equivalent.

5.2   Base Units:

The OWCP has adopted the anesthesia base unit values that CMS has assigned to each anesthesia procedure code and reflects the difficulty of the anesthesia services, including the usual pre-operative and post-operative care and evaluation. The base unit is used to determine a portion of the reimbursement amount of the anesthesia procedure.

Note: Anesthesia base units are automatically calculated and should <u>not</u> be reported on the claim form.

The Base Units Effective_July_9_2022 can be found at:

http://www.dol.gov/OWCP/regs/feeschedule/fee.htm

5.3 Conversion Factors:

OWCP anesthesia conversion factors are determined for each locality where services are performed. A single conversion factor will be used for all qualified anesthesia practitioners (e.g., physician and non-physician).

When all anesthesia practitioners involved in a procedure are associated in the same group, one practitioner may provide the pre-anesthesia exam and the other practitioner can perform the medical direction and post-anesthesia care. Medical records must indicate the name of the practitioner who performed the specific service.

The anesthesia conversion factors Effective_July_9_2023 can be found at:

http://www.dol.gov/OWCP/regs/feeschedule/fee.htm

Note: The OWCP anesthesia conversion factors are listed by payment locality and are effective for dates of service on or after July 1, 2022. If zip code or locality is not found the conversion factor is defaulted to one (1).

The following calculations are used when processing claims for anesthesia services:

1. The 15-minute time interval will be divided into the total time indicated on the bill. Total time should always be accurately reported in minutes. Actual time units will be paid.
   Example:
$$\textbf{120 minutes} \quad \div \quad \frac{\textbf{1 unit}}{\textbf{15min}} \quad = \textbf{8 time units}$$

2. The total units derived from Step 1 will constitute total units for time.

3. The time units will be added to the base units assigned to the anesthesia procedure code. If multiple anesthetic procedures are performed during a single operative session, the procedure with the highest base units will be used for this calculation.

4. The final step will result in the calculation of maximum allowable amount compared to the billed amount.

Anesthesiologists and CRNAs must report anesthesia time in total minutes in Item 24G of the OWCP-1500 claim form. Complete all other items as required according to the OWCP-1500 claim form instructions.

OWCP-1500 Example:
If total time for anesthesia is one hour, enter 120 minutes in Item 24G.

5.4   Reimbursement Examples:

(Time Units + Base Units) x Conversion Factor = Allowance

Example #1: *(This is an example only. Providers should check their current anesthesia conversion factors for correct fee amounts.)*

> Code: 00830©
> Modifier: AA
> Time: 120 minutes
> Locality: Dallas (zip code 75201)
> Time: 120 minutes = 120 ÷ 15   = 8 units
> Code: 00830©, base units   + 4 units
>   12 units

  Conversion factor, Dallas =   53.55

  Total units = 12 x 53.55 = $642.60

  The physician's maximum allowed amount would be $642.60

Example #2: (T*his is an example only. Providers should check their current anesthesia conversion factors for correct fee amounts.)*

> Code: 00830©
> Modifier: AA
> Time: 129 minutes
> Locality: Dallas (zip code 75201)
> Time: 129 minutes = 129 ÷ 15 = 8.6 units*   9 units
> Code: 00830©, base units   + 4 units
>   13 units

  Conversion factor, Dallas =   53.55

  Total units = 13 x 53.55 = $696.15

  The physician's maximum allowed amount would be $696.15

*When time units calculate to a number with a decimal time unit of .5 or higher the unit is rounded up to the next whole number.

Example #3: (T*his is an example only. Providers should check their current anesthesia conversion factors for correct fee amounts.*)

Code: 00830$^{©}$
Modifier: AA
Time: 123 minutes
Locality: Dallas (zip code 75201)
Time: 123 minutes = 123 ÷15 = 8.2 units**   8 units
Code: 00830$^{©}$, base units   + 4 units
                                                                                 12 units

Conversion factor, Dallas =   53.55

 Total units = 12 x 53.55 = $642.60

The physician's maximum allowed amount would be $642.60

** When time units calculate to a number with a decimal time unit of .4 or lower the unit is rounded down to the closest whole number.

6.0   REIMBURSEMENT REQUIREMENTS FOR MULTIPLE ANESTHESIA SERVICES AND ADD-ON ANESTHESIA CODES:

The OWCP provides reimbursement requirements for multiple anesthesia services during the same operative session, repeat anesthesia procedure on the same day the original anesthesia service was provided, or the use of add-on codes.

6.1   Supporting Documentation:

The OWCP requires that supporting medical documentation be submitted when billing for multiple anesthesia services during the same operative session or the medical necessity for the repeat procedure(s) performed on the same day of the original anesthesia service. It may also be necessary to include appropriate add-on codes or modifiers 76 and 77 for the repeat anesthesia service to fulfill reimbursement. Failure to provide supporting documentation or the appropriate modifiers may delay reimbursement or indicate a duplicate service.

6.2 Multiple Services - Same Operative Session:

Reimbursement can be made for anesthesia services associated with multiple surgical procedures. When multiple anesthesia services are performed during the same operative session, the OWCP reimbursement policy is based on the anesthesia procedure with the highest base unit value. The total time units will equal the actual anesthesia time for both procedures.

Example:

Provider	Date of Service	Procedure	Modifier	Time	Base Units
ABC	07/01/2022	00700©	AA	120 minutes	4
ABC	07/01/2022	00730©	AA	60 minutes	5

Payment for the multiple procedures will be based on code 00730©, which has the highest base unit value (5), plus a total time period of 180 minutes = 12 time units.

6.3 Repeat Procedure or Service by Same Physician - Modifier 76:

The patient is returned to the operating room on the same day for the same or a related procedure. The same physician who is performing the repeat service must bill the repeat procedure using modifier 76.

Example:

Provider	Date of Service	Procedure	Modifier
ABC	07/01/2022	00730©	AA – (First Service)
ABC	07/01/2022	00730©	AA , 76 – (Repeat Service)

6.4 Repeat Procedure by a Different Physician - Modifier 77:

When a patient is taken back to surgery on the same day for the same or a related procedure by a different physician than the original physician who performed the first service, the different physician must bill the repeat procedure using modifier 77.

Example:

Provider	Date of Service	Procedure	Modifier
ABC	07/01/2022	00730©	AA – (First Service)
XYZ	07/01/2022	00730©	AA, 77 – (Repeat Service)

6.5 Add-On Codes for Anesthesia Services:

Anesthesia add-on codes are priced differently than multiple anesthesia codes. Only the base unit(s) of the add-on code will be allowed. All anesthesia time should be reported with the primary anesthesia code. See exception below in the obstetrical area.

Add-on codes for anesthesia involving burn excisions or debridement and obstetrical anesthesia are:

01952$^©$ Anesth, burn 4-9 percent – *primary code*
01953$^©$ Anesth, burn each add'l 9 percent – *add-on code*
01967$^©$ Anesth, analg vag delivery – *primary code*
01968$^©$ Anes/analg cs deliver add-on – *add-on code*
01969$^©$ Anesth/analg cs hyst add-on – *add-on code*

The add-on codes should be billed in addition to the primary anesthesia code. *For example, in the burn area, anesthesia time should be reported with code 01952$^©$. Anesthesia time would not be reported with the add-on code 01953$^©$. One unit (not time) per additional 9 percent total body surface area or part thereof should be reported with code 01953$^©$. This would be reported in the Units field (Item 24g) on the OWCP-1500 form or electronic equivalent.*

There is an exception for obstetrical anesthesia. Therefore, OWCP requires for the obstetrical add-on codes, that the anesthesia time be separately reported with each of the primary and the add-on codes based on the amount of time appropriately associated with either code. Both the base unit and the time units for the primary and the add-on obstetrical anesthesia codes are recognized.

7.0 OTHER ANESTHESIA SERVICE CAVEATS AND REIMBURSEMENT:

This section defines other anesthesia services that may be performed by a qualified physician or non-physician and OWCP's reimbursement determination.

7.1 Blood Gas Monitoring:

Blood gas monitoring performed as part of an Anesthesiologist's service is considered to be an integral part of the anesthesia service and is <u>not</u> reimbursed separately.

7.2 Bundled Anesthesia Services:

These are considered to be bundled services:

99100$^©$ Special anesthesia service
99116$^©$ Anesthesia with hypothermia

99135© Special anesthesia procedure
99140© Emergency anesthesia

Separate payment will <u>not</u> be allowed for these services; payment will be bundled into the anesthesia allowance.

7.3 Pre-Anesthetic Exams/Cancelled Surgery:

A pre-anesthetic examination and evaluation of a patient who does not undergo surgery may be considered for reimbursement. Reimbursement is determined under the physician fee schedule for the medical or surgical service. Non-medically directed CRNAs should report the pre-anesthetic examination and evaluation for a patient whose surgery is cancelled using one of the subsequent hospital care codes (99231©–99233©). It is inappropriate to use the initial hospital care codes. No separate payment will be made in cases of medically directed CRNAs because it is assumed the Anesthesiologist furnished these services.

7.4 Electroconvulsive Therapy (ECT) – 90870©:

Electroconvulsive Therapy (ECT) is used in the treatment of depression and related disorders and other severe psychiatric conditions.

When a psychiatrist administers the anesthesia for the ECT procedure, no separate payment is made for the anesthesia service.

7.5 Anesthesia Services Furnished by the Same Physician Providing the Medical and Surgical Service:

Physicians who both perform and provide moderate sedation for medical/surgical services will be paid for the conscious sedation consistent with CPT guidelines. However, physicians who perform and provide local or minimal sedation for these procedures will not be paid separately for the sedation services.

Providers should ensure their billing staffs are aware of this reimbursement policy that addresses the same physician performing both the medical/surgical service and the conscious sedation service.

The continuum of complexity in anesthesia services (from least intense to most intense) ranges from:

> Local or topical anesthesia.
> Moderate (conscious) sedation.
> Regional anesthesia.

To,

General anesthesia.

Moderate sedation is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. It does not include minimal sedation, deep sedation or monitored anesthesia care.

If the physician performing the procedure also provides moderate sedation for the procedure, reimbursement may be made for conscious sedation consistent with CPT guidelines; however, if the physician performing the procedure provides local or minimal sedation for the procedure, no separate payment is made for the local or minimal sedation service.

Payment will not be allowed for codes 99144© & 99145© and 99149© & 99150© if any of these codes are performed on the same day with a medical/surgical service listed in Appendix G of the CPT book and the service is provided in a non-facility setting. A facility is defined as one with a place of service code of 21, 22, 23, 24, 26, 31, 34, 41, 42, 51, 52, 53, 56 or 61.

Two of these codes (99144© and 99145©) describe the scenario in which the same physician performing the diagnostic or therapeutic procedure provides the moderate sedation, and an independent trained observer's presence is required to assist in monitoring the patient's level of consciousness and physiological status. The other two codes (99149© and 99150©) describe the scenario in which the moderate sedation is provided by a physician other than the one performing the diagnostic or therapeutic procedure.

1   CPT coding guidelines for conscious sedation codes instruct practices not to report codes 99144© and 99145© in conjunction with the codes listed in CPT Appendix G

2   In the unusual event that a second physician (other than the one performing the diagnostic or therapeutic services) provides moderate sedation in the facility setting for the procedures listed in CPT Appendix G, the second physician can bill codes 99149© and 99150© but cannot report these codes when the second physician performs these services (on the same day as a medical/surgical service) in the non-facility setting.

3   If an Anesthesiologist or CRNA provides anesthesia for diagnostic or therapeutic nerve blocks or injections, and a different provider performs the block or injection, the Anesthesiologist or CRNA may report the anesthesia service using CPT code 01991©. In this case, the service must meet the criteria for monitored anesthesia care. If the Anesthesiologist or CRNA provides both the anesthesia service and the block or injection, the Anesthesiologist or CRNA may report the anesthesia service using the conscious sedation code and the injection or block. However, the

anesthesia service must meet the requirements for conscious sedation, and if a lower level complexity anesthesia service is provided, the conscious sedation code should not be reported.

4   There is no CPT code for the performance of local anesthesia, and as such, reimbursement for this service is considered to be part of the payment for the underlying medical or surgical service.   Therefore, no additional OWCP reimbursement is provided for local anesthesia.

5   If the physician performing the medical or surgical procedure that includes local anesthesia reports a conscious sedation code, OWCP will not provide reimbursement without supporting documentation indicating the medical necessity of conscious sedation.