

PART II
POLICIES AND PROCEDURES
For
SCHEDULE OF MAXIMUM ALLOWABLE CPT ANESTHESIA BASE UNITS



DIVISION OF MEDICAID
July 1, 2022

Policy Revisions Record

Part II Policies and Procedures Manual for Schedule of Maximum Allowable CPT

Anesthesia Base Units Services

Policy Revisions Record

Part II Policies and Procedures Manual for Schedule of Maximum Allowable CPT

Anesthesia Base Units Services

REVISION DATE	SECTION	REVISION DESCRIPTION	REVISION TYPE	CITATION
			A=Added D=Deleted M=Modified	(Revision required by Regulation, Legislation, etc.)
01/01/2022		Change Header & Foot to reflect 01/01/2022	M	
01/01/2022		Added New HCPCs 2022 Codes – (Bolded)	A	
04/01/2022		No updates for April posting		
07/01/2022		No Policy Updates for July Posting		

PREFACE

This manual contains basic information concerning Georgia's Fee for Service (FFS) Medicaid and PeachCare for Kids' Schedule of Allowable CPT Anesthesia Codes with Base Units (SAAC) and should be used in conjunction with the Part I Policies and Procedures Manual for Medicaid and PeachCare for Kids, the Part II Policies and Procedures Manual for Physicians Service, and other applicable program manuals.

We urge you and your office staff to familiarize yourself with the contents of this manual and refer to it when questions arise.

Use of the manuals will assist in the elimination of misunderstandings concerning the coverage levels and billing procedures that can result in claim processing or payment delays, inaccuracies, and/or denials.

The SAAC is reviewed and updated quarterly, consistent with the American Society of Anesthesiologist (ASA).

When such updates are made, they will be posted on the Georgia Health Partnership's (GHP) website at www.mmis.georgia.gov, which shall constitute formal notice to providers. The amended provisions will be effective on the date of the notice or as specified by the notice itself, and all providers are responsible for complying with the amended manual revisions as of their effective dates.

Thank you for your participation and interest in Georgia's Medicaid/PeachCare for Kids program. Your service is greatly appreciated.

General

Regional or Spinal Analgesia for Pain Management - Services performed by an anesthesiologist for pain management are reimbursable only when medically necessary for intractable pain, e.g., advanced cancer. These services must be billed on the Physician/Practitioner Invoice (CMS1500 Claim form) using Type of Service “2.” Daily management of the epidural must be billed under procedure code 01996.

Monitored Anesthesia Care (MAC), administered as anesthesia for medical or surgical procedures must be billed on the Physician / Practitioner Invoice (CMS 1500 claim form) using procedure code **D9239**, for **initial** and **D9243 each subsequent 15-minute increment**.
***Note* D9239 and D9243 do not go through the Anesthesia pricing logic; they will be paid using the Flat Rate pricing.**

Please note that MAC involves the intraoperative monitoring by a physician of the patient's vital physiological signs in anticipation of the need for administration of general anesthesia or the development of adverse physiological patient reaction to the surgical procedure. It also includes the performance of a pre-anesthetic examination and evaluation, prescription of the anesthesia care required, administration of any necessary oral or parenteral medications (e.g., Atropine, Demerol, and Valium) and provision of indicated post-operative anesthesia care.

Just because the physician personally furnished or medically directed the MAC does not automatically mean that the MAC is a covered service. The MAC must be reasonable and medically necessary under the given circumstances.

Rev.04/07 General anesthesia rendered for all procedures, including dental, must be billed using the most appropriate CPT anesthesia codes, 00172-00176 that best identifies the surgical procedure performed.

Where applicable, the schedule lists the number of anesthesia base units (BU) allowed. The BU are added to the Time Units of anesthesia to determine the total units allowed for the service. If qualifying special conditions for anesthesia exist, additional units are added as follow:

Rev. 1/02 Special Condition Units

Rev. 7/03	Use Modifier	To Report	Additional Unit(s)
	P3	If the patient has a severe systemic, but not incapacitating disease	1
	P4	If the patient has a severe systemic and incapacitating disease	2
	P5	If the patient is moribund and is not expected to survive twenty-four hours without the operation	3

Additional units may also be added from a following line with an anesthesia modifier, if the following line meets the criteria below. The following line does not need an anesthesia modifier:

Use CPT Code	To Report	Additional Unit(s)
99100	Member's age is one (1) year old or less based on line item from date of service; or when medically necessary for children up to 21 years old who need anesthesia for dental procedures (verify if this is still applicable).	1
99100	Member's age is greater than 70 years old based on the line item from date of service.	1
99140	For all emergencies	2

10/21/03 Effective for date of service (DOS) on or after October 21, 2003, claims for anesthesia services must be submitted using total time in minutes, with each 15 minutes or any part thereof, being equaled to one (1) unit on the CMS 1500 claims form, in accordance with Part II Policy and Procedure for Physician Services, Section 903.1—Anesthesia Services.

Example: to bill anesthesia time of two (2) hours and 35 minutes, enter 155 minutes in field 24G on the CMS 1500 claim form.

Do not add base or physical status units as the MHN system automatically adds the appropriate base and physical status units according to the CPT and physical status codes billed.

Rev. 1/00 The sum of Base Units plus Time Units plus Special Condition Units, if applicable, is multiplied times the conversion factor for anesthesia services.

The conversion factor for service dates beginning on or after January 1, 1992, is \$16.00 for all geographic areas when filing modifier AA or 78. For modifiers QK and QY, the conversion factor is \$5.58. Modifier QX and QZ conversion factors are \$10.42 and \$15.84, respectively.

If a CPT procedure is non-covered, anesthesia for that service is also non-covered. The following CPT Anesthesia Codes with Units are to be used in conjunction with Part II Policy and Procedures for Physician Services, Section 903.1—Anesthesia Services.

Reimbursement for anesthesia services includes the usual preoperative and post-operative visits, the administration of the anesthetic, and the administration of fluids and/or services "incident to" the anesthesia or surgery.

10/21/03

Effective for date of service (DOS) on or after October 21, 2003, claims for anesthesia services must be submitted using total time in minutes, with each 15 minutes or any part thereof, being equaled to one (1) unit on the CMS 1500 claims form, in accordance with Part II Policy and Procedure for Physician Services, Section 903.1—Anesthesia Services.

Example: to bill anesthesia time of two (2) hours and 35 minutes, enter 155 minutes in field 24G on the CMS 1500 claim form.

Do not add base or physical status units as the MHN system automatically adds the appropriate base and physical status units according to the CPT and physical status codes billed.

Anesthesia Reimbursement Formula

Reimbursement for general anesthesia is calculated using the following formula:

$$AC = CF (BU + TU)$$

AC = Allowed Charge

CF = Conversion Factor

BU = Base Units

TU = Time Units

Allowed Charge—is the maximum amount payable by the Division for anesthesia services. The amount paid is the lesser of the submitted charge or the amount calculated in the formula.

Conversion Factor—is a single unit rate used to calculate reimbursement for all anesthesiology services. This figure is determined by the Division in accordance with federal regulations.

Rev 04/00

Base Units—are assigned to establish the relative difficulty of each service. These numbers are derived from Relative Value Studies, which, in turn, are derived from charge patterns.

Time Units—are calculated as the total time required for the service. One time unit is fifteen minutes.

If special conditions are indicated on the claim, additional base units may be assigned by the Division in the calculation.

The accepted modifiers include:

AA	Anesthesia services personally rendered by an Anesthesiologist
\$16.00	
QK	Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving
\$5.58	qualified individual(s) [CRNA's] or [PAAA's] by an anesthesiologist.
QX	Medically Directed—salaried employee of Anesthesiology (CRNA or
\$10.42	PAAA
QY	Medical direction of on anesthesia procedure involving a qualified
\$5.58	individual [CRNA's] or [PAAA's] by anesthesiologist
QZ	Anesthesia services personally rendered by a Registered Nurse Anesthetist
\$15.84	(CRNA).

Please Note If the rendering provider's specialty is (031) Certified Registered Nurse Anesthetist or (204) Physician Assistant Anesthetist the system bypasses the cut back logic of 90% for the above provider specialties only.

Anesthesia Reimbursement Other:

Clarified
04/07

Certain anesthesia services may be subject to the lower of billed charges or a standard reimbursement rate; and is not subject to the anesthesia calculation formula.

Anesthesia services reimbursed at the standard reimbursement rate include, but may not be limited to:

01967 Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)

⁺01968 Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed)

⁺01969 Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed).

Use applicable modifier—AA, QK, QX, QY, or QZ, to report/bill the standard reimbursement anesthesia services.

The plus sign indicates an add-on code.

NOTE: CPT codes 01968 and 01969 are add-on codes that must be listed separately in addition to the primary procedure, 01967.

In accordance with CPT, add-on codes are always performed in addition to the primary service or procedure and must NEVER be reported as a stand-alone code.

Effective July 1, 2010 the Department will make an exception to the aforementioned CPT coding guidelines and allow split billing of the primary (01967-AA) and add-on (01968 & 01969—QX) CPT anesthesia/epidural codes by the anesthesiologist and the CRNA and PAAA when performing the services for the same patient on the same date of service. The aforementioned exception to add-on code billing is applicable to anesthesia codes 01967, 01968, and 01969 **ONLY**, when billed with the appropriate modifiers.

Example: Anesthesiologist bills 01967 AA
PAAA or CRNA bills 01968 or 01969 with QX
For the same member, same DOS

PAAA – Physician Assistant Anesthesiologist Assistant / Anesthesiologist Assistant

CRNA – Registered Nurse Anesthetist

DOS – Date of service

Labor Epidural codes 01967 & 01968 are reimbursed on a flat rate.

Code	Modifier	Rate Amount
01967	AA	\$ 248.50
	QK	\$ 82.83
	QY	\$ 82.83
	QX	\$165.66
	QZ	\$ 246.02
01968	AA	\$ 400.00
	QK	\$133.33
	QY	\$133.33
	QX	\$266.66
	QZ	\$ 396.00

CPT CODES	BASE UNITS	CPT CODES	BASE UNITS	CPT CODES	BASE UNITS	CPT CODES	BASE UNITS	CPT CODES	BASE UNITS	CPT CODES	BASE UNITS
00100	5	00500	15	00796	30	00936	8	01462	3	01832	6
00102	6	00520	6	00797	11	00938	4	01464	3	01840	6
00103	5	00522	4	00800	4	00940	3	01470	3	01842	6
00104	4	00524	4	00802	5	00942	4	01472	5	01844	6
00120	5	00528	8	00811	4	00944	6	01474	5	01850	3
00124	4	00529	11	00812	4	00948	4	01480	3	01852	4
00126	4	00530	4	00813	5	00950	5	01482	4	01860	3
00140	5	00532	4	00820	5	00952	4	01484	4	01916	5
00142	6	00534	7	00830	4	01112	5	01486	7	01920	7
00144	6	00537	10	00832	6	01120	6	01490	3	01922	7
00145	6	00539	18	00834	5	01130	3	01500	8	01924	6
00147	6	00540	12	00836	6	01140	15	01502	6	01925	8
00148	4	00541	15	00840	6	01150	10	01520	3	01926	10
00160	5	00542	15	00842	4	01160	4	01522	5	01930	5
00162	7	00546	15	00844	7	01170	8	01610	5	01931	7
00164	4	00548	17	00846	8	01173	12	01620	4	01932	7
00170	5	00550	10	00848	8	01200	4	01622	4	01933	8
00172	6	00560	15	00851	6	01202	4	01630	5	01935	5
00174	6	00561	25	00860	6	01210	6	01634	9	01937	4
00176	7	00562	20	00862	7	01212	10	01636	15	01938	4
00190	5	00563	25	00864	8	01214	8	01638	10	01939	4
00192	7	00567	18	00865	7	01215	10	01650	6	01940	4
00210	11	00566	25	00866	10	01220	4	01652	10	01941	5
00211	10	00580	20	00868	10	01230	6	01654	8	01942	5
00212	5	00600	10	00870	5	01232	5	01656	10	01951	3
00214	9	00604	13	00872	7	01234	8	01670	4	+ 01953	1
00215	9	00620	10	00873	5	01250	4	01680	3	01958	5
00216	15	00625	13	00880	15	01260	3	01710	3	01960	5
00218	13	00626	15	00882	10	01270	8	01712	5	01961	7
00220	10	00630	8	00902	5	01272	4	01714	5	01962	8
00222	6	00632	7	00904	7	01274	6	01716	5	01963	10
00300	5	00635	4	00906	4	01320	4	01730	3	01965	4
00320	6	00640	3	00908	6	01340	4	01732	3	01966	4
00322	3	00670	13	00910	3	01360	5	01740	4	01969	5
00326	8	00700	4	00912	5	01380	3	01742	5	01990	7
00350	10	00702	4	00914	5	01382	3	01744	5	01991	3
00352	5	00730	5	00916	5	01390	3	01756	6	01992	5
00400	3	00731	5	00918	5	01392	4	01758	5	01996	3
00402	5	00732	6	00920	3	01400	4	01760	7		
00404	5	00750	4	00921	3	01402	7	01770	6		
00406	13	00752	6	00922	6	01404	5	01772	6		
00410	4	00754	7	00924	4	01420	3	01780	3		
00450	5	00756	7	00926	4	01430	3	01782	4		
00454	3	00770	15	00928	6	01432	6	01810	3		
00470	6	00790	7	00930	4	01440	8	01820	3		
00472	10	00792	13	00932	4	01442	8	01829	3		
00474	13	00794	8	00934	6	01444	8	01830	3		

Schedule of Allowable CPT Anesthesia Codes with Base Units