Anesthesia Bundling

Purpose

This policy is intended to ensure correct provider reimbursement and serves only as a general resource regarding Molina Healthcare's reimbursement policy for the services described in this policy. It is not intended to address every aspect of a reimbursement situation, nor is it intended to impact care decisions. This policy was developed using nationally accepted industry standards and coding principles. In a conflict, federal and state guidelines, as applicable, and the member's benefit plan document supersede the information in this policy. Also, to the extent of conflicts between this policy and the provider contract language, the Provider contract language will prevail. Coverage may be mandated by applicable legal requirements of a State, the Federal government or the Centers for Medicare and Medicaid Services (CMS). References included were accurate at the time of policy approval. If there is a state exception, please refer to the state exception table listed below.

Policy Overview

The anesthesia HCPCS/CPT codes encompass all critical aspects of the anesthesia process, including preoperative preparations, continuous monitoring, intraoperative care, and postoperative care until the patient is transferred by the anesthesia practitioner to another physician. The National Correct Coding Initiative (NCCI) program includes edits that combine standard preparation, monitoring, and procedural services into anesthesia CPT (Current Procedural Terminology) codes. Unless it is specifically indicated that charges are separate and distinct from the anesthesia provided during the surgical procedure, it is assumed that any services billed for preparation, monitoring, and procedural services are included in the associated anesthesia provisions and will be bundled into the primary anesthesia code. Anesthesia care is provided by an anesthesia practitioner, who may be a physician, a certified registered nurse anesthetist (CRNA) with or without medical direction, or an anesthesia assistant (AA) with medical direction. The anesthesia care package includes preoperative evaluation, standard preparation and monitoring services, administration of anesthesia, and post-anesthesia recovery care. Anesthesia services include various activities such as preoperative patient evaluation, administration of anesthetic medications, monitoring of physiological parameters, and other supportive services.

Examples of the codes are:

- 00100 - Anesthesia for procedures on the eyelids
- 00300 - Anesthesia for procedures on the nose and accessory sinuses
- 00400 - Anesthesia for procedures on the lips
- 00532 - Anesthesia for procedures on the salivary glands
- 00740 - Anesthesia for procedures on the liver, biliary tract, or pancreas
- 00810 - Anesthesia for procedures on the upper anterior abdominal wall
- 00902 - Anesthesia for procedures on the female genital system
- 01402 - Anesthesia for procedures on the spine and spinal cord
- 01610 - Anesthesia for procedures on the upper arm and elbow
- 01991 - Anesthesia for procedures on the lower leg and ankle

Reimbursement Guidelines

Introduction

These reimbursement guidelines provide instructions for the billing and reimbursement of certain CPT codes billed with an anesthesia code. When these services are billed together, they are considered part of the anesthesia service and will be included in the primary anesthesia code. However, in some instances, these services may be performed separately from the anesthesia provision for that day, and in such cases, they may be reimbursed independently if specific criteria are met.

Bundling of Service

Primary Anesthesia Code

When a CPT code is billed alongside an anesthesia code, it is regarded as part of the anesthesia service and will be incorporated into the primary anesthesia code. The reimbursement for these services will be included in the payment for the primary anesthesia procedure.

Same Date of Surgery

Many procedures billed with an anesthesia code may occur on the same date as the surgery. In such instances, these services are generally not performed during the provision of anesthesia for the day and will still be bundled into the primary anesthesia code.

Separate Reimbursement Criteria

Modifier 59, XU, XE

Modifiers XE, XU, XP, and XS are part of the HCPCS modifiers established by CMS to provide a more accurate alternative to modifier 59.

- **XE**
- **XU**

Use these specific modifiers over modifier 59 when possible. Modifier 59 should only be used when no other specific modifier applies. Proper medical documentation is required to support their use.
Services billed with an anesthesia code may qualify for separate reimbursement under certain criteria. To show that the service was independent of anesthesia, append the appropriate modifier to the CPT code.

Independent Services

To qualify for separate reimbursement, the service billed with the anesthesia code must meet the following criteria:

A. The service is distinct and independent from the anesthesia service provided.
B. The service is necessary and reasonable for the patient's condition.
C. The service is not considered routine or inherent to the anesthesia procedure.

Documentation Requirements

To support separate reimbursement for services billed with an anesthesia code, the following documentation should be maintained:

A. Detailed description of the service provided, including the medical necessity.
B. Documentation establishing the service as distinct and independent from the anesthesia service.
C. Any supporting clinical documentation, such as operative reports or procedure notes.

Billing and Coding Instructions

- ***Primary Anesthesia Code***

When billing for the primary anesthesia procedure, the appropriate anesthesia code should be reported.

- ***Modifier XU, XE, 59***

When billing for services that may qualify for separate reimbursement, the appropriate modifier should be appended to the specific CPT code.

(For Examples, please see Policy overview)

Molina Healthcare reimbursement amounts will be determined based on the fee schedules applicable to your services and the terms specified in the provider contract. It is essential to comply with the billing guidelines provided by the specific state Medicaid program and/or the Centers for Medicare and Medicaid Services (CMS). Neglecting to include the required indicators or documentation with your submitted charges may lead to potential delays, denials, or audits during the claim payment process.

Recovery Process:

In instances where overpayments are identified during the audit process, Molina Healthcare will initiate a recovery process. This may involve recouping the overpaid amount from future payments or directly from the provider. Underpayments identified will be duly reimbursed to the provider.

Review and Revisions:

Molina Healthcare will periodically review this policy, making updates as necessary to align with changes in coding standards, regulatory guidelines, or internal audit processes.

Supplemental Information

Definitions

Term	Definition
CMS	Centers for Medicare and Medicaid Services
HCPCS	Healthcare Common Procedure Coding System
CPT	Current Procedural Terminology
NCCI	National Correct Coding Initiative
CRNA	Certified registered nurse anesthetist
AA	Anesthesia assistant

References

State/Agency	Document Name/Description	Link/Document
CMS	CHAPTER II: ANESTHESIA SERVICES CPT CODES 00000- 01999 FOR NATIONAL CORRECT CODING INITIATIVE POLICY MANUAL FOR MEDICARE SERVICES	Anesthesia Services Policy Manual

Documentation History

Type	Date	Action
Effective	10/23/2023	
Revised Date	12/12/2024	Updated Template

Disclaimer's

This policy is subject to updates based on changes in legal or regulatory guidelines. Providers are encouraged to regularly review policy updates published on Molina Healthcare's provider website. This policy is designed to provide guidance and is not a guarantee of payment. Healthcare providers should make medical necessity determinations based on the individual clinical circumstances of each patient.

***CODING DISCLAIMER**. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed*