**Reference Guide to Calculate Michigan
Workers' Compensation Maximum Allowable Payment for Anesthesia
Fee Schedule Effective: 12/26/2012**

- ***Note***: *Codes listed with "0" or not listed are BR (By Report). A BR procedure is reimbursed at the provider's usual and customary charge or reasonable amount, defined in the definition section of the Health Care Services Rules, whichever is less.*
- *The absence or presence of a code does not indicate workers' compensation coverage.*
- *Please refer to the Health Care Services Manual for additional information.*

ANESTHESIA

Calculate the Michigan Maximum Allowable Payment (MAP) using the following formula:

Medicare Anesthesia Base Units + Time Units (rounded to the tenth) x $42 (Michigan conversion amount) = Michigan MAP, rounded

Factors used to calculate base units and time units:
- **Base Units**:
  The *Anesthesia Base Units by CPT Code* table is available on our website at www.michigan.gov/wca.
- **Physical Risk Modifiers**:
  P1 - A normal healthy patient – 0 base units
  P2 - A patient with mild systemic disease – 0 base units
  P3 - A patient with severe systemic disease – 1 base unit
  P4 - A patient with severe systemic disease that is a constant threat to life – 2 base units
  P5 - A moribund patient who is expected not to survive without the operation – 3 base units
  P6 - A declared brain-dead patient whose organs are being removed for donor purposes – 0 base units
- **Procedure Code 99140**:
  Shall be billed as an add-on procedure if an emergency condition, as defined in R 418.10108, complicates anesthesia – 2 base units
- **Time units (rounded to the tenth)**:
  1 Time Unit = Increments of 15 minutes or portions thereof, for administration of the anesthesia.
  1 Time Unit = Increments of 30 minutes or portions thereof, for supervision of a CRNA.
- **Modifiers**:
  AA - Anesthesiologist administers the anesthesia
  QK - Anesthesiologist provides medical direction for the CRNA
  QX - CRNA, supervised by Anesthesiologist, administers the anesthesia
  QZ - CRNA administers without supervision of the Anesthesiologist
- **NOTE:** If a surgeon provides the anesthesia service, the surgeon will only be reimbursed the base units for the anesthesia procedure.

Health Care Services Rules for reference:
- **R 418.10915** Billing for anesthesia services.

Rule 915. (1) Anesthesia services shall consist of 2 components. The 2 components are base units and time units. Each anesthesia procedure code is assigned a value for reporting the base units. The base units for an anesthesia procedure shall be as specified in the publication entitled "Medicare RBRVS: The Physicians' Guide" as adopted by reference in R 418.10107. The anesthesia codes, base units and instructions for billing the anesthesia service shall be published separate from these rules in the health care services manual.

(2) An anesthesia service may be administered by either an anesthesiologist, anesthesia resident, a certified registered nurse anesthetist, or a combination of a certified registered nurse anesthetist, and a physician providing medical direction or supervision. When billing for both the anesthesiologist and a certified registered nurse anesthetist, the anesthesia procedure code shall be listed on 2 lines of the CMS 1500 with the appropriate modifier on each line.

(3) One of the following modifiers shall be added to the anesthesia procedure code to determine the appropriate payment for the time units:

(a) Modifier -AA indicates the anesthesia service is administered by the anesthesiologist.

(b) Modifier -QK indicates the anesthesiologist has provided medical direction for a certified registered nurse anesthetist, CRNA, or resident. The CRNA or resident may be employed by either a hospital, the anesthesiologist or may be self-employed.

(c) Modifier -QX indicates the certified registered nurse anesthetist has administered the procedure under the medical direction of the anesthesiologist.

(d) Modifier -QZ indicates the certified registered nurse anesthetist has administered the complete anesthesia service without medical direction of an anesthesiologist.

(4) Total anesthesia units shall be calculated by adding the anesthesia base units to the anesthesia time units.

(5) Anesthesia services may be administered by any of the following:

(a) A licensed doctor of dental surgery.

(b) A licensed doctor of medicine.

(c) A licensed doctor of osteopathy.

(d) A licensed doctor of podiatry.

(e) A certified registered nurse anesthetist.

(f) A licensed anesthesiology resident.

(6) If a surgeon provides the anesthesia service, the surgeon will only be reimbursed the base units for the anesthesia procedure.

(7) If a provider bills physical status modifiers, then documentation shall be included with the bill to support the additional risk factors. When billed, the physical status modifiers are assigned unit values as defined in the following table:

Anesthesiology Physical Status Modifiers Unit Value P1 A normal healthy patient. 0 P2 A patient who has a mild systemic disease. 0 P3 A patient who has a severe systemic disease. 1 P4 A patient who has a severe systemic disease that is a constant threat to life. 2 P5 A moribund patient who is expected not to survive without the operation. 3 P6 A declared brain-dead patient whose organs are being removed for donor purposes. 0

(8) Procedure code 99140 shall be billed as an add-on procedure if an emergency condition, as defined in R 418.10108, complicates anesthesia. Procedure code 99140 shall be assigned 2 anesthesia units. Documentation supporting the emergency shall be attached to the bill.

(9) If a pre-anesthesia evaluation is performed and surgery is not subsequently performed, then the service shall be reported as an evaluation and management service.

History: 2000 AACS; 2003 AACS; 2005 AACS.

- **R 418.101007** Reimbursement for anesthesia services.

Rule 1007. (1) The carrier shall determine the maximum allowable payment for anesthesia services by adding the base units to the time units. The carrier shall reimburse anesthesia services at either the maximum allowable payment, or the practitioner's usual and customary charge, whichever is less. Each anesthesia base unit shall be multiplied by $42.00 to determine payment for the base procedure.

    (a) Anesthesia base units shall only be paid to an anesthesiologist, a surgeon who provides the anesthesia and performs the surgery, or a certified registered nurse anesthetist providing anesthesia without medical direction of the anesthesiologist. Only 1 practitioner shall be reimbursed for base units, documented by the anesthesia record.

(2) The carrier shall reimburse the time units by the total minutes listed in the "days" or "units" column and the alpha modifier added to the procedure code. Time units are reimbursed in:

    (a) Increments of 15 minutes or portions thereof, for administration of the anesthesia.

    (b) Increments of 30 minutes or portions thereof, for supervision of a CRNA.

    (c) In no instance shall less than 1 time unit be reimbursed.

(3) The maximum allowable payment for anesthesia time shall be calculated in the following manner:

    (a) If the anesthesiologist administers the anesthesia, then the modifier shall be -AA and the maximum payment shall be $2.80 per minute.

    (b) If the anesthesiologist supervises a CRNA, then the modifier shall be -SA and the maximum payment shall be $1.40 per minute.

    (c) If a CRNA supervised by an anesthesiologist administers the anesthesia, then the modifier shall be -QX and the maximum payment shall be $2.80 per minute.

    (d) If a CRNA administers without supervision of the anesthesiologist, then the modifier shall be -QZ and the maximum payment shall be $2.80 per minute.

NOTE: **In R 418.101007(3)(b) above, the modifier is incorrectly referred to as -SA and should be -QK**.