Title 8, California Code of Regulations
Division 1, Chapter 4.5

ARTICLE 5.3

[§9789.10 unchanged.]

[§9789.11 unchanged.]

§ 9789.12.1 Physician Fee Schedule: Official Medical Fee Schedule for Physician and Non-Physician Professional Provider Services – For Services Rendered On or After 10/1/2010

(a) Maximum reasonable fees for physician and non-physician professional medical treatment provided pursuant to Labor Code section 4600, which is rendered on or after October 1, 2010, shall be no more than the amount determined by the Official Medical Fee Schedule for Physician and Non-Physician Professional Provider Services, consisting of the regulations set forth in Sections 9789.12.1 through 9789.18.1 ("Physician Fee Schedule.") The Physician Fee Schedule shall not govern fees for services covered by a contract setting such fees as permitted by Labor Code section 5307.11.

(b) Maximum fees for services of a physician or non-physician professional medical services provider, are governed by the Physician Fee Schedule, regardless of specialty, for services performed within his or her scope of practice or license as defined by California law, except for:
(1) E/M codes which are to be used by physicians (as defined by Labor Code §3209.3), as well as physician assistants and nurse practitioners who are acting within the scope of their practice and are under the direction of a supervising physician;
(2) Physical Medicine and Rehabilitation Evaluation codes (97001 and 97002) which are to be used only by physical therapists;
(3) Occupational Therapy Evaluation codes (97003 and 97004) which are to be used only by occupational therapists; and
(4) Osteopathic Manipulation Codes (98925-98929) which are to be used only by licensed Doctors of Osteopathy and Medical Doctors.

(c) Physicians and non-physician professional medical service providers shall consult other parts of the OMFS to determine maximum fees for services or goods not covered by the Physician Fee Schedule, such as pharmaceuticals (section 9789.40), pathology and clinical laboratory (section 9789.50) and durable medical equipment, prosthetics, orthotics, supplies (section 9789.60).

§ 9789.12.2 Definitions

(a) "AA" is an Anesthesiologist Assistant.

(b) "Base Maximum Reasonable Fee" means the amount calculated as the maximum reasonable fee according to the basic fee formula, RVU * CF = Fee, or, for anesthesia, (Base Unit + Time Unit) * CF = Fee, prior to application of other fee schedule rules or

modifiers that adjust the base maximum fee to establish the final maximum reasonable fee.

(c) "By Report" or "BR" means that the service is an unusual or variable service not covered by an established Relative Value Unit, and that the fee for the service must be justified by report.

(d) "California Specific Codes" means codes developed by the Division of Workers' Compensation to define procedures not covered by CPT, or for which there is a need for a special California workers' compensation code. These codes consist of five characters beginning with WC and followed by three numbers. For example: WC001.

(e) "California Specific Modifiers" means two-digit modifiers developed by the Division of Workers' Compensation to add identifying information not covered by CPT modifiers, or for which there is a need for a special California workers' compensation modifier.

(f) "CMS" means the Center for Medicare & Medicaid Services of the United States Department of Health and Human Services.

(g) "Conversion factor" is the number that is multiplied by the relative value (or base units plus time units for anesthesia) to produce the base maximum reasonable fee.

(h) "CPT " or "Current Procedural Terminology" is the book *Current Procedural Terminology, Standard Edition*, Fourth Edition, copyright by the American Medical Association.

(i) "CRNA" is a Certified Registered Nurse Anesthetist licensed by the state.

(j) "Facility" means that the site of service receives or is eligible to receive a facility fee payment related to the procedure.

(k) "National Physician Fee Schedule Relative Value File" is the file published annually by CMS that contains Relative Value Units and other payment-related data.

(l) "Non-Facility" means that the site of service does not allow for a facility fee payment related to the procedure.

(m) "Physician Fee Schedule ground rule" is a rule or provision affecting billing or payment that is in the text of the Physician Fee Schedule regulations or in any document incorporated by reference.

(n) "RBRVS" or "Resource Based Relative Value Scale" means the relative value scale created by the Center for Medicare and Medicaid Services set forth in the Federal Register for each calendar year.

(o) "Teaching Physician" is a physician (other than another resident) who involves residents in the care of his or her patients.

§ 9789.12.3 Relative Value Units (RVUs)

The data in the following columns of the CMS' National Physician Fee Schedule Relative Value File are utilized to determine the maximum reasonable fees: HCPCS (except alpha-numeric codes), Modifier, Description, Status Code, Resource Based Relative Value Units (Total Facility and Total Non-Facility), PC/TC Indicator, Global Days, Pre Operative, Intra Operative, Post Operative, Multiple Procedure, Bilateral Surgery, Assistant Surgeon, Co-Surgeon, Team Surgeon, Endoscopic Base Code, and Diagnostic Imaging Family Indicator.

For services rendered on or after October 1, 2010, the Administrative Director incorporates by reference the specified portions of the 2010 National Physician Fee Schedule Relative Value File, revised 1/8/2010, entitled "PPRRVU10" which can be accessed at:
http://www.cms.hhs.gov/PhysicianFeeSched/PFSRVF/itemdetail.asp?filterType=dual,%20data&filterValue=2010&filterByDID=1&sortByDID=1&sortOrder=ascending&itemID=CMS1230197&intNumPerPage=10
The columns of the PPRRVU10 which are incorporated by reference include:

Column A	HCPCS (except the alpha-numeric codes)
Column B	Modifier
Column C	Description
Column D	Status Code (except G, I, N, R)
Column Q	Fully Implemented Non-Facility Total RVUs
Column S	Fully Implemented Facility Total RVUs
Column T	PC/TC Indicator
Column U	Global Days
Column V	Pre Operative
Column W	Intra Operative
Column X	Post Operative
Column Y	Multiple Procedure
Column Z	Bilateral Surgery
Column AA	Assistant Surgeon
Column AB	Co-Surgeon
Column AC	Team Surgeon
Column AD	Endoscopic Base Code
Column AH	Diagnostic Imaging Family Indicator

§ 9789.12.4 Conversion Factors

The conversion factor(s) for physician and non-physician professional medical services shall be as follows:

(a) Anesthesia services (codes listed in the anesthesia section of the CPT):

For services rendered on or after October 1, 2010: $33.9815143289

(b) For medical treatment services other than anesthesia (codes listed, respectively, in the surgery, radiology, and all other sections of the CPT):

	Surgery	Radiology	All Other
For services rendered on or after October 1, 2010	53.12508522	59.5335055	40.70478871
For services rendered on or after October 1, 2011	49.9375801	53.5801549	42.50707112
For services rendered on or after October 1, 2012	46.9413253	48.2221394	44.16981332
For services rendered on or after October 1, 2013	45.14766194	45.1476619	45.14766194

§ 9789.12.5 Calculation of the Maximum Reasonable Fee - Services Other than Anesthesia

Except for fees determined in §9789.17.1 et seq., (Anesthesia), the base maximum reasonable fee for physician and non-physician professional medical provider services shall be the non-facility or facility fee calculated as follows:

(a) Non-facility site of service fee calculation:

For services rendered on or after October 1, 2010:

Fully Implemented Non-Facility Total RVU (Column Q) * CF = Base Maximum Fee

The base maximum fee for the procedure code is the maximum reasonable fee, except as otherwise provided by applicable provisions of this fee schedule, including but not limited to the application of ground rules and modifiers that effect reimbursement.

(b) Facility site of service fee calculation:

For services rendered on or after October 1, 2010:

Fully Implemented Facility Total RVU (Column S) * CF = Base Maximum Fee

The base maximum fee for the procedure code is the maximum reasonable fee, except as otherwise provided by applicable provisions of this fee schedule, including but not limited to the application of ground rules and modifiers that effect reimbursement.

(c)(1) "Total Facility RVU" shall be used to calculate the fee for services furnished to a patient in the hospital (inpatient or outpatient), comprehensive inpatient rehabilitation facility, inpatient psychiatric facility, skilled nursing facility, community mental health center, or ambulatory surgical center.
(2)"Total Non-Facility RVU" shall be used to calculate the fee for services furnished to a patient in the physician's or non-physician provider's office, the patient's home, or in a facility or institution other than those listed above as the site for use of "Total Facility RVU."

§ 9789.13.1 Coding; Current Procedural Terminology ©, Fourth Edition

(a) The coding, modifiers, guidelines, appendices and all other provisions of *Current Procedural Terminology* ©, Fourth Edition, published by the American Medical Association are applicable to the bills submitted for physician and non-physician professional medical services, except that any regulation in the Physician Fee Schedule that conflicts with a provision in *CPT* will take precedence over the *CPT*.

For services rendered on or after October 1, 2010, the Administrative Director incorporates by reference the American Medical Association's "Current Procedural Terminology," 4th Edition, Revised 2010.

(b) Copies of *Current Procedural Terminology* ©, Fourth Edition may be purchased from the American Medical Association:

Order Department
American Medical Association
P.O. Box 930876
Atlanta, GA 31193-0876

Or over the internet at: www.amapress.com

Or American Medical Association's toll free order line: (800) 621-8335

§ 9789.13.2 California Specific Codes

Physicians shall use the "California Specific Codes" listed below. Maximum reasonable fees for services performed by providers within their scope of practice shall be no more than the fee listed below for the procedure.

CA Code	Reference to Fee (If Any)	Procedure
WC001	**Not Reimbursable**	**Doctor's First Report of Occupational Illness or Injury (Form 5021) (Section 9789.14.1(a)(1))**
WC002	**$37.98**	**Treating Physician's Progress Report (PR-2 or narrative equivalent in accordance with § 9785) (Section 9789.14.1(b)(1))**
WC003	**$37.98 for first page $23.37 each additional page. Maximum of six pages absent prior authorization ($154.83)**	**Primary Treating Physician's Permanent and Stationary Report (Form PR-3) (Section 9789.14.1(b)(2))**
WC004	**$37.98 for first page $23.37 each additional page. Maximum of seven pages absent prior authorization ($178.20)**	**Primary Treating Physician's Permanent and Stationary Report (Form PR-4) (Section 9789.14.1(b)(3))**
WC005	**Not Reimbursable**	**Functional Improvement Report (Form FIR) (Section 9789.14.1(a)(2))**

WC006	**$37.98 for first page $23.37 each additional page. Maximum of six pages absent prior authorization ($154.83)**	**Other Provider Report – Not Legally Mandated (Section 9789.14.1(b)(4))**
WC007	**$37.98 for first page $23.37 each additional page. Maximum of six pages absent prior authorization ($154.83)**	**Consultation Reports (Section 9789.14.1(b)(5))**
WC008	**$10.00 for up to the first 15 pages. $0.25 for each additional page after the first 15 pages.**	**Chart Notes (Section 9789.14.1(c))**
WC009	**$10.00 for up to the first 15 pages. $0.25 for each additional page after the first 15 pages.**	**Duplicate Reports (Section 9789.14.1(d))**
WC010	**$ 5.00 per x-ray**	**Duplication of X-Ray**
WC011	**$10.00 per scan**	**Duplication of Scan**
WC012	**$62.50 for each quarter hour or portion thereof spent by the treating physician**	**Medical Testimony (reimburse for all itemized reasonable and necessary time spent related to the testimony, including reasonable preparation and travel time, rounded to the nearest quarter hour. A minimum of one hour shall be reimbursed for a scheduled deposition, even if less than one hour is spent.)**
WC013	**No Fee Prescribed / Non Reimbursable absent agreement**	**Missed Appointments. This code is designated for communication only. It does not imply that compensation is owed.**

§ 9789.13.3 California-Specific Modifiers

(a) The following modifiers are to be appended to the applicable CPT Code or California Specific code in addition to any applicable CPT modifier.

-01 **Primary treating physician report/service:**
This modifier shall be used to identify a required report issued or E&M service performed by the primary treating physician. This modifier shall be appended to each of the following codes, as appropriate: evaluation and management codes, report codes and prolonged service codes.

-02 **Secondary treating physician report/service:**
This modifier shall be used to identify a required report issued or E&M service performed by the secondary treating physician. This modifier shall be appended to each of the following codes, as appropriate: evaluation and management codes, report codes and prolonged service codes.

-03 **Non-physician provider report/service:**
This modifier shall be used to identify a required report issued by, or E&M service performed by, a non-physician professional provider.

-04 **Consultant Report/service:**
This modifier shall be used to identify a report issued by, or E&M service performed by, a Consultant. This modifier shall be appended to each of the following codes, as appropriate: evaluation and management codes, report codes and prolonged service codes.

-05 **Consultation Service During Medical-Legal Evaluation:**
This modifier shall be used to identify services or procedures performed by a consultant in the context of a medical-legal evaluation where those services are paid under the Physician Fee Schedule.

-83 **Surgical Assistant Services Provided by a Licensed Non-Physician Professional Provider**
This modifier shall be used to identify services performed by licensed non-physician professional providers acting within their scope of practice, and used in lieu of an assistant physician. Reimbursed at 10% of allowable surgical fee.

-93 **Interpreter Required at the Time of Examination:**
Where this modifier is applicable, the value of the evaluation and management service is modified by multiplying the normal value by 1.1. Prolonged service codes may not be used in combination with this modifier unless it is documented that the reason for the code is additional time required as a result of factors beyond the need for an interpreter.

§ 9789.13.4 Evaluation and Management Coding – New Patient

For purposes of workers' compensation billing, the CPT definitions of "new patient" and "established patient" are altered as follows:
(a) A "new patient" is one who is new to the physician or an established patient with a new industrial injury or illness. Only one new patient visit is reimbursable to a single physician or medical group per specialty for evaluation of the same patient relating to the same incident, injury or illness.
(b) An "established patient" is a patient who has been seen previously for the same industrial injury or illness by the physician.

§ 9789.13.5 Consultation Services Coding – use of visit codes

Maximum fees for physicians performing consultation services shall be determined utilizing the appropriate RVU for a patient evaluation and management visit. Physicians shall code consultation visits as patient evaluation and management visits utilizing the CPT Evaluation and Management codes that represent where the visit occurs and that identify the complexity of the visit performed. In the inpatient hospital setting and the nursing facility setting all physicians (and qualified non-physician providers where

permitted) who perform an initial evaluation may bill the initial hospital care codes (99221 – 99223) or nursing facility care codes (99304 – 99306).

Follow-up consultation visits in the inpatient hospital setting shall be billed as subsequent hospital care visits (99231 – 99233) and subsequent nursing facility care visits (99307 - 99310.)

In the office or other outpatient setting where a consultation / evaluation is performed, physicians and qualified non-physician providers shall use the CPT codes (99201 – 99215) depending on the complexity of the visit and whether the patient is a new or established patient to that physician.

§ 9789.13.6 Correct Coding Initiative

The National Correct Coding Initiative Edits ("NCCI") adopted by the CMS shall apply to payments for medical services under the Physicians Fee Schedule. Claims administrators shall apply the NCCI coding edits and medically unlikely edits to bills to determine appropriate payment. Claims Administrators shall utilize the National Correct Coding Initiative Coding Policy Manual for Medicare Services (Coding Policy Manual) as a general reference tool that explains the rationale for NCCI edits. If a billing is reduced or denied reimbursement because of application of the NCCI, the claims administrator must notify the provider of the basis for the denial, including the fact that the determination was made in accordance with the NCCI.

The NCCI Edits Manual may be obtained from the CMS website: http://www.cms.hhs.gov/NationalCorrectCodInitEd/. The CMS website contains a listing of the NCCI edits, by specific CPT sections, and is available free for downloading to the public.

The Manual may also be purchased from the National Technical Information Service (NTIS) at:
http://www.ntis.gov/products/cci.aspx
or by contacting NTIS at 1-800-363-2068 or 703-605-6060.

For services rendered on or after October 1, 2010, the Administrative Director incorporates by reference the National Correct Coding Initiative Edits - Physicians and the National Correct Coding Initiative Coding Policy Manual for Medicare Services, version 15.3, effective October 1, 2009.

§ 9789.13.7 "By Report" - Reimbursement for Unlisted Procedures / Procedures Lacking RBRVUs

(a) An unlisted procedure shall be billed using the appropriate unlisted procedure code from the CPT. The procedure shall be billed by report, justifying that the service was reasonable and necessary to cure or relieve from the effects of the industrial injury or illness.

(b) Unless otherwise provided in the Physician Fee Schedule, for a procedure that appears in the CPT, but does not have an RVU assigned in the CMS' National Physician Fee

Schedule file (for example, CPT codes with Status Code "C" - "Carriers price the code"), the procedure shall be billed by report, justifying that the service was reasonable and necessary to cure or relieve from the effects of the industrial injury or illness. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure, and the time, effort and equipment necessary to provide the service.

(c) In some instances, the value of a By Report procedure may be determined using the value assigned to a comparable procedure. The comparable procedure should reflect the same amount of time, complexity, expertise, etc. as required for the procedure performed.

§ 9789.14.1 Reimbursement for Reports, Duplicate Reports, Chart Notes

This section governs reimbursement of all reports other than those which are payable under the medical-legal fee schedule, found at section 9793 et seq. The medical-legal fee schedule should only be used for the reimbursement of reports which are requested by a party for the purpose of proving or disproving a contested claim. Reports obtained for the purpose of determining whether to accept or contest a claim are governed by this section. This section covers all treatment reports required by statute or regulation, and consulting reports which are requested by a party.

(a) Treatment Reports Not Separately Reimbursable.
The following treatment reports are not separately reimbursable as the appropriate fee is included within the underlying Evaluation and Management service, Physical Therapy Evaluation service or Occupational Therapy Evaluation service for an office visit:
(1) Doctor's First Report of Occupational Illness or Injury (Form 5021) issued in accordance with section 9785(e). Use Code WC001;
(2) Functional Improvement Report (DWC Form FIR) issued in accordance with section 9785(g)(2). Use Code WC005.

(b) Treatment Reports That Are Separately Reimbursable.
The following treatment reports are separately reimbursable. Where an office visit is included, the report charge is payable in addition to the underlying Evaluation and Management service for an office visit.

(1) Treating Physician's Progress Report (Form PR-2), by primary treating physician or secondary treating physician, issued in accordance with section 9785(f), using DWC form PR-2, its narrative equivalent, or letter format where allowed by section 9785. Use Code WC002. Maximum reimbursement is $37.98.

(2) Primary Treating Physician's Permanent and Stationary Report (Form PR-3) issued in accordance with section 9785(i). Use Code WC003. The physician may also report the appropriate *Current Procedural Terminology* Evaluation and Management code, if any, and, when appropriate, prolonged service codes. Maximum reimbursement is $37.98 for first page, plus $23.37, for each additional page. Maximum of six pages absent prior authorization. Maximum total reimbursement is $154.83.

(3) Primary Treating Physician's Permanent and Stationary Report (Form PR-4) issued in accordance with section 9785(i). Use Code WC004. The physician may also report the appropriate *Current Procedural Terminology* Evaluation and Management code, if any, and, when appropriate, prolonged service codes. Maximum reimbursement is $37.98 for first page, plus $23.37, for each additional page. Maximum of seven pages absent prior authorization. Maximum total reimbursement is $178.20.

(4) Provider Reports That Are Not Legally Mandated. When a claims administrator or its authorized agent requests that a provider complete a form that is not legally mandated or submit information in excess of that required pursuant to section 9785, the provider shall be separately reimbursed using code WC006. Maximum reimbursement is $37.98 for first page, plus $23.37, for each additional page. Maximum of six pages absent prior authorization. Maximum total reimbursement is $154.83.

(5) Consultation Reports that are separately reimbursable. The following reports are separately reimbursable. Where an examination of the patient is performed, the report charge is payable in addition to the underlying Evaluation and Management visit code. Use Code WC007. Where there is no examination of the patient, see "Prolonged Service Codes", below.

(A) A report by a consulting physician, where consultation was requested on one or more medical issues by the treating physician, including a second medical opinion on the necessity or appropriateness of previously recommended medical treatment or a surgical procedure.

(B) A report by a consulting physician, where consultation was requested on one or more medical issues by a party, the Administrative Director, or the Workers' Compensation Appeals Board. Reports included under this section are those reports that are admissible and reimbursable in accordance with Labor Code section 4064(d).

(C) A report by the treating physician, where medical information other than that required to be reported under the treatment report section above was requested by a party, the Administrative Director, or the Workers' Compensation Appeals Board.

(D) A report by a consulting physician where the claim does not meet the criteria of a "contested claim" as set forth in 8 CCR § 9793(b).

(E) A consultation code may not be billed when care or any part of care has been clearly transferred by the primary treating physician to another physician.

(c) Chart Notes. Requests for chart notes shall be in writing and shall be separately reimbursable. Chart note requests shall be made only by the claims administrator. Use Code WC008 to bill for chart notes "By Report", using these guidelines. Maximum reimbursement is: $10.00 for up to the first 15 pages, plus $0.25 for each additional page in excess of 15 pages.

(d) Duplicate Reports. A primary treating physician has fulfilled his or her reporting duties by sending one copy of a required report to the claims administrator or to a person designated by the claims administrator to be the recipient of the required report.

Requests for duplicate reports related to billings shall be made only by the claims administrator and shall be in writing. Duplicate reports are separately reimbursable. Use Code WC009 to bill for duplicate reports "By Report", using these guidelines. Maximum reimbursement is: $10.00 for up to the first 15 pages, plus $0.25 for each additional page in excess of 15 pages.

§9789.15.1 Physical Medicine / Chiropractic / Acupuncture Multiple Procedure Cascade; Procedure/Modality Limitation; Assessment

(a) Maximum reimbursement for multiple physical medicine procedures, modalities, acupuncture procedures, chiropractic manipulative treatment codes billed on the same visit will be as follows:

- Major (highest valued allowable procedure, modality or treatment): 100% of listed maximum allowable fee
- Second (second highest valued allowable procedure, modality or treatment): 75% of listed maximum allowable fee
- Third (third highest valued allowable procedure, modality or treatment): 50% of listed maximum allowable fee
- Fourth (fourth highest valued allowable procedure, modality or treatment): 25% of listed maximum allowable fee

The following codes are subject to the multiple procedure reduction set forth above:

97010 through 97028
97032 through 97039
97110
97112
97113
97116
97124
97139
97140
97150
97530
97532
97533
97535
97537
97542
97760
97761
97810
97811
97813
97814
98940
98941

98942
98943

(b) No more than one physical medicine modality (a code listed in the "Modalities" section of "Medicine" in CPT) and three therapeutic procedures/chiropractic manipulation procedures/acupuncture procedures (codes in the listed in the "Therapeutic Procedures" or "Acupuncture" or "Chiropractic Manipulative Treatment" sections of "Medicine" in CPT), total of four codes, may be reimbursed in one visit.

§9789.16.1 Surgery – Global Fee; Multiple Procedures; Bilateral Procedures; Rules Affecting Fee Calculation

(a) Global Surgical Package.
A global surgical package refers to a payment policy of bundling payment for the various services associated with an operation into a single payment covering the operation and these other services.

(1) Definition of a Global Surgical Package. The National Physician Fee Schedule Relative Value File, (PPRRVU), column "U" – "Global Days", provides the postoperative periods that apply to each surgical procedure. The payment rules for surgical procedures apply to codes with entries of 000, 010, 090, and, sometimes, YYY.
(A) Codes with "000" in column U are endoscopic or minor procedures with related preoperative and postoperative relative values on the day of the procedure only included in the fee schedule payment amount; evaluation and management services on the day of the procedure are generally not payable.
(B) Codes with "010" in column U are minor procedures with preoperative relative values on the day of the procedure and postoperative relative values during a 10 day postoperative period included in the fee schedule amount; evaluation and management services on the day of the procedure and during the 10-day postoperative period generally not payable.
(C) Codes with "090" in column U are major surgeries with a 1-day preoperative period and 90-day postoperative period included in the fee schedule amount.
(D) Codes with "YYY" are claims administrator-priced codes, for which claims administrators determine whether the global concept applies and establishes postoperative period, if appropriate. The global period for these codes will be 0, 10, or 90 days.
(E) Codes with "ZZZ" are surgical codes related to another service and are always included in the global period of the other service. They are add-on codes that are always billed with another service. There is no postoperative work included in the fee schedule payment for the "ZZZ" codes. Payment is made for both the primary and the add-on codes, and the global period assigned is applied to the primary code.

(2) Components of a Global Surgical Package. A global surgical package is applied to all procedures with the appropriate entry in column U of the National Physician Fee Schedule Relative Value File. The services included in the global surgical package may be furnished in any setting, e.g., in hospitals, ASCs, physicians' offices. Visits to a patient in an intensive care or critical care unit are also included if made by the surgeon. However, critical care services (99291 and 99292) are payable separately in some

situations. The global fee for these procedures includes payment for the following services related to the surgery when furnished by the physician who performs the surgery:
(A) Preoperative Visits - Preoperative visits after the decision is made to operate beginning with the day before the day of surgery for major procedures and the day of surgery for minor procedures;
(B) Intra-operative Services - Intra-operative services that are normally a usual and necessary part of a surgical procedure;
(C) Complications Following Surgery - All additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications which do not require additional trips to the operating room (OR). For the purposes of this section, an operating room is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient's room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient's condition was so critical there would be insufficient time for transportation to an OR);
(D) Postoperative Visits - Follow-up visits during the postoperative period of the surgery that are related to recovery from the surgery;
(E) Postsurgical Pain Management - By the surgeon;
(F) Supplies - Except for those identified as exclusions; and
(G) Miscellaneous Services - Items such as dressing changes; local incisional care; removal of operative pack; removal of cutaneous sutures and staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation and removal of urinary catheters, routine peripheral intravenous lines, nasogastric and rectal tubes; and changes and removal of tracheostomy tubes.

(3) Services Not Included in the Global Surgical Package. The services listed below may be paid for separately:
(A) The initial consultation or evaluation of the problem by the surgeon to determine the need for a major surgical procedure. The initial evaluation is always included in the allowance for a minor surgical procedure;
(B) Services of other physicians except where the surgeon and the other physician(s) agree on the transfer of care;
(C) Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complications of the surgery;
(D) Treatment for the underlying condition or an added course of treatment which is not part of normal recovery from surgery;
(E) Diagnostic tests and procedures, including diagnostic radiological procedures;
(F) Clearly distinct surgical procedures during the postoperative period which are not re-operations or treatment for complications. (A new postoperative period begins with the subsequent procedure.) This includes procedures done in two or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure. Examples of this are procedures to diagnose and treat epilepsy (codes 61533, 61534-61536, 61539, 61541, and 61543) which may be performed in succession within 90 days of each other;
(G) Treatment for postoperative complications which requires a return trip to the operating room (OR);

(H) If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is payable separately;
(I) Splints and casting supplies are payable separately;
(J) Immunosuppressive therapy for organ transplants; and
(K) Critical care services (codes 99291 and 99292) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician.

(4) Minor Surgeries and Endoscopies. Visits by the same physician on the same day as a minor surgery or endoscopy are included in the payment for the procedure, unless a significant, separately identifiable service is also performed. A postoperative period of 10 days applies to some minor surgeries. The postoperative period for these procedures is indicated in column U of the National Physician Fee Schedule Relative Value File. If the column U entry is "010", no separate payment is allowed for postoperative visits or services within 10 days of the surgery that are related to recovery from the procedure. If a diagnostic biopsy with a 10-day global period precedes a major surgery on the same day or in the 10-day period, the major surgery is payable separately. Services by other physicians are not included in the global fee for a minor procedure except as otherwise excluded. If the column U entry is "000", postoperative visits beyond the day of the procedure are not included in the payment amount for the surgery. Separate payment is made in this instance.

(5) Physicians Furnishing Less Than the Full Global Package. There are occasions when more than one physician provides services included in the global surgical package. It may be the case that the physician who performs the surgical procedure does not furnish the follow-up care. Payment for the postoperative, post-discharge care is split between two or more physicians where the physicians agree on the transfer of care. When more than one physician furnishes services that are included in the global surgical package, the sum of the amount approved for all physicians may not exceed what would have been paid if a single physician provides all services, except where permitted. When either modifier "-54" or "-55" is used, a percentage of the fee schedule is applied as appropriate. The percentages for pre-, intra-, and postoperative care of the total RVUs for major surgical procedures and for minor surgeries with a postoperative period of 10 days may be found in columns V, W, and X respectively, of the National Physician Fee Schedule Relative Value File. The intra-operative percentage includes postoperative hospital visits. Split global care does apply to procedures with "000" in column U of the National Physician Fee Schedule Relative Value File.

(6) Determining the Duration of a Global Period. To determine the global period for major surgeries, count 1 day immediately before the day of surgery, the day of surgery, and the 90 days immediately following the day of surgery. To determine the global period for minor procedures, count the day of surgery and the appropriate number of days (either 0 or 10 days) immediately following the date of surgery.

(7) Coding Requirements for Global Surgeries.
(A) Physicians who perform the surgery and furnish all of the usual pre-and postoperative work will receive payment for the global package by entering the appropriate CPT code for the surgical procedure only. Separate payment is not allowed for visits or other services that are included in the global package.

(B) Where physicians agree on the transfer of care during the global period, use modifier "-54" for surgical care only, and use modifier "-55" for postoperative management only. If the transfer of care occurs immediately after surgery, the physician other than the surgeon providing the in-hospital postoperative care should use the "-55" modifier for the post-discharge care, and the surgeon should use the "-54" modifier.
(C) Where a transfer of care does not occur, occasional post-discharge services of a physician other than the surgeon are reported by the appropriate evaluation and management code. No modifiers are necessary on the claim.
(D) Physicians who provide follow-up services for minor procedures performed in emergency departments use the appropriate level of office visit code. The physician who performs the emergency room service uses the CPT for the surgical procedure without a modifier.
(E) If the services of a physician other than the surgeon are required during a postoperative period for an underlying condition or medical complication, the other physician reports the appropriate evaluation and management code. No modifiers are necessary on the claim.

(8) Evaluation and Management Service Resulting in the Initial Decision to Perform Surgery. Evaluation and management services on the day before major surgery or on the day of major surgery that result in the initial decision to perform the surgery are not included in the global surgery payment for the major surgery and, therefore, may be paid separately. In addition to the CPT evaluation and management code, modifier "-57" (decision for surgery) is used to identify a visit which results in the initial decision to perform surgery. If evaluation and management services occur on the day of surgery, use modifier "-57," not "-25." The "-57" modifier is not used with minor surgeries because the global period for minor surgeries does not include the day prior to the surgery. Moreover, where the decision to perform the minor procedure is typically done immediately before the service, it is considered a routine preoperative service and a visit or consultation is not separately payable in addition to the procedure.

(9) Return Trips to the Operating Room During the Postoperative Period for Treatment of Complications. When treatment for complications requires a return trip to the operating room, use the CPT code that describes the procedure(s) performed during the return trip. If no such code exists, use the unspecified procedure code in the correct series, i.e., 47999 or 64999. The procedure code for the original surgery is not used except when the identical procedure is repeated. In addition to the CPT code, use CPT modifier "-78" for return trips (return to the operating room for a related procedure during a postoperative period). When another procedure was performed during the postoperative period of the initial procedure, and this subsequent procedure is related to the first procedure, and requires the use of the operating room, report this circumstance by adding the modifier "-78" to the related procedure.
(A) The amount of payment when modifier "-78" is added to the CPT code, is the value of the intra-operative services of the code that describes the treatment rendered. The percentage of the global package for the intra-operative service can be found at column W of the National Physician Fee Schedule Relative Value File. The fee schedule amount is multiplied by this percentage.
(B) When a CPT code with a "000" global period is coded with modifier "-78", representing a return trip to the operating room to deal with complications, the full value of the procedure is paid since these codes have no pre-, post-, or intra-operative values.

(C) When an unlisted procedure is performed, because no code exists to describe the treatment for complications, a maximum of 50 percent of the value of the intra-operative services originally performed is allowed.
(D) If multiple surgeries were originally performed, payment will be no more than 50 percent of the value of the intra-operative services of the surgery for which the complications occurred. Multiply the fee schedule amount for the original surgery by the intra-operative percentage for the procedure, and then multiply that figure by 50 percent to obtain the maximum payment allowed. [.50 X (fee schedule amount x intra-operative percentage)].
(E) If additional procedures are performed during the same operative session as the original surgery to treat complications which occurred during the original surgery, treat the additional procedures as multiple surgeries, pursuant to subsection (b). Only surgeries that require a return to the operating room are paid under this subsection.
(F) If the patient is returned to the operating room after the initial operative session, but on the same day as the original surgery for one or more additional procedures as a result of complications from the original surgery, this subsection applies to each procedure required to treat the complications from the original surgery. The multiple surgery rules under subsection (b) do not apply.
(G) If the patient is returned to the operating room during the postoperative period of the original surgery, not on the same day of the original surgery, for multiple procedures that are required as a result of complications from the original surgery, this subsection applies, and multiple surgery rules under subsection (b) do not apply.
(H) If the patient is returned to the operating room during the postoperative period of the original surgery, not on the same day of the original surgery, for bilateral procedures that are required as a result of complications from the original surgery, this subsection applies, and the bilateral rules under subsection (c) do not apply.

(10) Staged or Related Procedures. Use modifier "-58" for staged or related surgical procedures done during the postoperative period of the first procedure. This modifier is not used to report the treatment of a problem that requires a return to the operating room. Modifier "-58" is added to the staged procedure when the performance of a procedure or service during the postoperative period was:
(A) Planned prospectively or at the time of the original procedure;
(B) More extensive than the original procedure; or
(C) For therapy following a diagnostic surgical procedure.
A new postoperative period begins with the next procedure in the series.

(11) Unrelated Procedures or Visits During the Postoperative Period. CPT modifiers "-79" and "-24" are used for visits and other procedures which are furnished during the postoperative period of a surgical procedure, but which are not included in the payment for the surgical procedure.
(A) Modifier "-79" reports an unrelated procedure by the same physician during a postoperative period. A new postoperative period begins with the unrelated procedure.
(B) Modifier "-24"reports an unrelated evaluation and management service by same physician during a postoperative period. A physician who is responsible for postoperative care using modifier "-55" should also use modifier "-24" to report any unrelated visits.

(12) Significant Evaluation and Management on the Day of a Procedure. Modifier "-25" is used for evaluation and management services on the day of a procedure for which separate payment may be made. It is used to report a significant, separately identifiable evaluation and management service by the same physician on the day of a procedure.

(13) Critical Care. Critical care services provided during a global surgical period for a seriously injured or burned patient are not considered related to a surgical procedure and may be paid separately under the following circumstances. Preoperative and postoperative critical care may be paid in addition to a global fee if:
(A) The patient is critically ill and requires the constant attendance of the physician; and
(B) The critical care is above and beyond, and, in most instances, unrelated to the specific anatomic injury or general surgical procedure performed. Such patients are potentially unstable or have conditions that could pose a significant threat to life or risk of prolonged impairment. Use CPT codes 99291/99292 and modifier "-25" (for preoperative care) or "-24" (for postoperative care) for these critical care services.

(14) Unusual Circumstances. Add modifier "-22" to the CPT code for surgeries where services performed are significantly greater than usually required. Add "-52" modifier to the CPT code for surgeries where services performed are significantly less than usually required. Modifier "-22" should only be reported with procedure codes that have a global period of 0, 10, or 90 days. There is no such restriction on the use of modifier "-52."

(b) Multiple Surgeries.
Multiple surgeries are separate procedures performed by a single physician or physicians on the same patient at the same operative session or on the same day for which separate payment may be allowed. Co-surgeons, surgical teams, or assistants-at-surgery may participate in performing multiple surgeries on the same patient on the same day. Multiple surgeries are distinguished from procedures that are components of or incidental to a primary procedure. These intra-operative services, incidental surgeries, or components of more major surgeries are not separately billable. Column Y of the National Physician Fee Schedule Relative Value File indicates whether the standard payment policies for multiple surgeries apply or whether special payment policies apply.

(1) If column Y contains indicator "0", then no payment adjustment rules for multiple procedures apply. If procedure is performed on the same day as another procedure, base the payment on the lower of (a) the actual charge, or (b) the fee schedule amount for the procedure.

(2) If column Y contains indicator 2, standard payment adjustment rules for multiple procedures apply. If the procedure is performed on the same day as another procedure, rank the procedures in descending order by fee schedule amount and apply the appropriate reduction to this code:
(A) 100 percent of the fee schedule amount for the highest valued procedure; and
(B) 50 percent of the fee schedule amount for the second through the fifth highest valued procedures; or
(C) if more than five procedures with indicator "2", pay for the first five according to subsections (A) and (B) above and pay "by report" for the sixth and subsequent procedures. Payment determined on a "by report" basis should never be lower than 50 percent of the full payment amount. Pay by the unit for services that are already reduced

(e.g. 17003). Pay for 17340 only once per session, regardless of how many lesions were destroyed.

(3) If column Y contains indicator "3", special rules for multiple endoscopic procedures apply if procedure is performed with another endoscopy in the same family (i.e., another endoscopy that has the same base procedure). The base procedure for each code with this indicator is identified in the column AD, "Endo Base", of the National Physician Fee Schedule Relative Value File. Apply the multiple endoscopy rules to a family before ranking the family with the other procedures performed on the same day (for example, if multiple endoscopies in the same family are reported on the same day as endoscopies in another family or on the same day as a non-endoscopic procedure). Payment for the base procedure is included in the payment for the other endoscopy. Payment is the full value of the highest valued endoscopy, plus the difference between the next highest and the base endoscopy.
(A) If an endoscopic procedure with an indicator of "3" is billed with the "-51" modifier with other procedures that are **not** endoscopies, the standard multiple surgery rules apply under (2) of this subsection.
(B) When endoscopies are performed on the same day as unrelated endoscopies or other surgical procedures, payment will be as follows:
(i) Two unrelated endoscopies (e.g., 46606 and 43217): Apply the usual multiple surgery rules under (2) of this subsection;
(ii) Two sets of unrelated endoscopies (e.g., 43202 and 43217; 46606 and 46608): Apply the special endoscopy rules under (3) of this subsection to each series and then apply the multiple surgery rules under (2) of this subsection. Consider the total payment for each set of endoscopies as one service; and
(iii) Two related endoscopies and a third, unrelated procedure: Apply the special endoscopic rules under (3) of this subsection to the related endoscopies, and, then apply the multiple surgery rules under (2) of this subsection. Consider the total payment for the related endoscopies as one service and the unrelated endoscopy as another service.

(4) If column Y contains indicator "4", special rules for the technical component (TC) of diagnostic imaging procedures apply if procedure is billed with another diagnostic imaging procedure in the same family (per the diagnostic imaging family indicator, below). If procedure is reported in the same session on the same day as another procedure with the same family indicator, rank the procedures by fee schedule amount for the TC. Pay 100% for the highest priced procedure, and 75% for each subsequent procedure. Base the payment for subsequent procedures on the lower of (a) the actual charge, or (b) the fee schedule amount reduced by the appropriate percentage. The professional component (PC) is paid at 100% for all procedures.

(5) If column Y contains indicator "9", the payment under this subsection does not apply.

(6) For multiple surgeries by the same physician on the same day, report the more major surgical procedure without the multiple procedures modifier "-51." Report additional surgical procedures performed by the surgeon on the same day with modifier "-51."

(7) When two or more physicians each perform distinctly different, unrelated surgeries on the same patient on the same day (e.g., in some multiple trauma cases), the payment

adjustment rules under this subsection may not be applicable. In such cases, do not use modifier "-51" unless one of the surgeons individually performs multiple surgeries.

(8) If two or more multiple surgeries are of equal value, rank them in descending dollar order and base payment on the percentages listed above in (2) of this subsection. (i.e., 100 percent for the first billed procedure, 50 percent for the second, etc.).

(9) If any of the multiple surgeries are bilateral surgeries, consider the bilateral procedure pursuant to subsection (c) of this section at 150 percent as one payment amount, rank this with the remaining procedures, and apply the appropriate multiple surgery reductions.
(10) In cases of multiple interventional radiological procedures, both the radiology code and the primary surgical code are paid at 100 percent of the fee schedule amount. The subsequent surgical procedures are paid at the standard multiple surgical percentages under (2) of this subsection (50 percent, 50 percent, 50 percent and 50 percent).

(11) Subsection (a), global surgeries, is applicable to multiple surgeries.

(12) If the patient returns to the operating room after the initial operative session on the same day as a result of complications from the original surgery, subsection (a)(9) (the complications rules) apply to each procedure required to treat the complications from the original surgery. This section does not apply.

(13) If the patient is returned to the operating room during the postoperative period of the original surgery, not on the same day of the original surgery, for multiple procedures that are required as a result of complications from the original surgery, subsection (a)(9) (the complications rules) apply. This section does not apply.

(c) Bilateral Surgeries.
Bilateral surgeries are procedures performed on both sides of the body during the same operative session or on the same day. The terminology for some procedure codes includes the terms "bilateral" (e.g., code 27395; Lengthening of the hamstring tendon; multiple, bilateral.) or "unilateral or bilateral" (e.g., code 52290; cystourethroscopy; with ureteral meatotomy, unilateral or bilateral). The payment adjustment for bilateral surgeries does not apply to procedures identified by CPT as "bilateral" or "unilateral or bilateral" since the fee schedule reflects any additional work required for bilateral surgeries. Column Z of the National Physician Fee Schedule Relative Value File indicates whether the payment adjustment rules apply to a surgical procedure.

(1) If a procedure is not identified by its terminology as a bilateral procedure (or unilateral or bilateral), report the procedure with modifier "-50." If a procedure is identified by the terminology as bilateral (or unilateral or bilateral), as in codes 27395 and 52290, do not report the procedure with modifier "-50".
(A) If column Z of the National Physician Fee Schedule Relative Value File contains an indicator of "0," "2," or "3," the payment adjustment rules for bilateral surgeries do not apply. Payment is determined by the lower of the billed amount or 100 percent of the fee schedule amount unless other payment adjustment rules apply.
(B) If column Z of the National Physician Fee Schedule Relative Value File contains an indicator of "1," the standard payment adjustment for bilateral procedures apply.

Payment is determined by the lower of the billed amount or 150 percent of the fee schedule amount. (Multiply the payment amount for the surgery by 150 percent.)
(C) Subsection (a), global surgeries, is applicable to bilateral procedures.

(d) Co-surgeons and Team Surgeons.
Under some circumstances, the individual skills of two or more surgeons are required to perform surgery on the same patient during the same operative session. This may be required because of the complex nature of the procedure(s) and/or the patient's condition. In these cases, the additional physicians are not acting as assistants-at-surgery.
(1) If two surgeons (each in a different specialty) are required to perform a specific procedure, each surgeon bills for the procedure with a modifier "-62." Co-surgery also refers to surgical procedures involving two surgeons performing the parts of the procedure simultaneously, i.e., heart transplant or bilateral knee replacements. Column AB of the National Physician Fee Schedule Relative Value File identifies how certain services are paid. When column AB contains indicator "0", co-surgeons are not permitted for this procedure. If column AB contains indicators "1" or "2", payment for each physician is determined by the lower of the billed amount or 62.5 percent of the fee schedule amount.

(2) If a team of surgeons (more than 2 surgeons of different specialties) is required to perform a specific procedure, each surgeon bills for the procedure with a modifier "-66." Column AC of the National Physician Fee Schedule Relative Value File identifies how certain services are paid. When column AC contains indicator "0", team surgeons are not permitted for this procedure and indictors "1" and "2" allow payment "by report".

(3) If surgeons of different specialties are each performing a different procedure (with specific CPT codes), neither this subsection (co-surgery) nor subsection (b) (multiple surgery) apply even if the procedures are performed through the same incision. If one of the surgeons performs multiple procedures, subsection (b) (multiple surgery) applies to that surgeon's services.

(4) Subsection (a) (global surgical packages) are applicable to each of the physicians participating in a co- or team surgery.

(e) Assistants-at-Surgery.
Assistants-at-surgery services are identified by modifiers "-80" (assistant surgeon), "-81" (minimum assistant surgeon), "-82" (assistant surgeon (when a qualified resident surgeon not available)), and California-specific modifier, "-83" (surgical assistant services provided by a licensed non-physician health care provider).

(1) Surgical assistant services is identified by adding modifier "-80" to the usual procedure number(s) and are reimbursed at 20% of the fee schedule value for the surgical procedures.

(2) Minimum surgical assistant services are identified by adding modifier "-81"to the usual procedure number and are valued at 10% of the fee schedule value for the surgical procedure.

(3) The unavailability of a qualified resident surgeon is a prerequisite for use of modifier "-82" appended to the usual procedure number and are reimbursed at 20% of the fee schedule value of the surgical procedure(s).

(4) Services performed by licensed non-physician health care providers acting within their scope of practice and used in lieu of an assistant physician, are identified by adding California-specific modifier "-83" to the usual procedure number and are reimbursed at 10% of the fee schedule value for the surgical procedure(s).

(5) If column AA of the National Physician Fee Schedule Relative Value File contains an indicator of "0" or "1", assistant-at-surgery is not payable. If column AA contains indicator "2", the assistant at surgery may be paid.

(6) Payment is not generally allowed for an assistant surgeon when payment for either two surgeons (modifier "-62") or team surgeons (modifier "-66") is appropriate.

§ 9789.17.1 Calculation of the Maximum Reasonable Fee - Anesthesia

The maximum reasonable fee for physician and non-physician professional provider services shall be calculated as follows:

[Base Unit + Modifying Unit [if applicable] + Time Unit] * CF = Base Maximum Fee

The base maximum fee for the procedure code is the maximum reasonable fee, except as otherwise provided by applicable provisions of this fee schedule, including but not limited to the application of ground rules and modifiers that effect reimbursement.

§ 9789.17.2 Anesthesia Base Units

For services rendered on or after October 1, 2010, the Administrative Director incorporates by reference the 2010 Anesthesia Base Units by CPT Code file issued by CMS, entitled "2010BASEfin" which can be accessed at:
http://www.cms.gov/center/anesth.asp

§ 9789.17.3 Anesthesia Time and Calculation of Anesthesia Time Units

(a) Anesthesia time is defined as the period during which an "anesthesia practitioner" is present with the patient. It starts when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the patient, that is, when the patient may be placed safely under postoperative care. Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service. 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.
(b) The physician or non-physician professional provider shall report actual anesthesia time in minutes.
(c) Time units are calculated by dividing the actual anesthesia time in minutes by 15 minutes. Round the time unit to one decimal place.

(d) Time units are not allowed for CPT codes 01995 or 01996.
(e) For purposes of this section, "anesthesia practitioner" means a physician who performs the anesthesia service alone, a CRNA who is not medically directed, or a CRNA or AA, who is medically directed. The physician who medically directs the CRNA or AA would ordinarily report the same time as the CRNA or AA reports for the CRNA service.

§9789.17.4 Anesthesia – Physical Status Modifiers

The Physical Status Modifiers contained in the CPT Anesthesia Guidelines shall be appended to the CPT code. Where a Physical Status Modifier is applicable, the base unit(s) used in calculating the maximum fee may be increased by adding the number of units indicated for the modifier:

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

§9789.17.5 Anesthesia – Qualifying circumstances

CPT Guidelines set forth Qualifying Circumstances and codes for anesthesia that is provided under particularly difficult circumstances. Where a Qualifying Circumstance exists, the base unit(s) used in calculating the maximum fee may be increased by adding the number of units indicated below.

CPT Code	Description (See CPT for complete descriptor)	Unit Value
99100	Anesthesia for patient of extreme age, under 1 year/over 70 years	1
99116	Anesthesia complicated by total body hypothermia	5
99135	Anesthesia complicated by utilization of controlled hypotension	5
99140	Anesthesia complicated by emergency conditions (specify)	2

§9789.17.6 Anesthesia Claims Modifiers

Physicians shall report the appropriate specific anesthesia modifier to denote whether the service was personally performed, medically directed, or medically supervised in addition to any applicable CPT modifier.

Specific anesthesia modifiers include:

AA - Anesthesia Services performed personally by the anesthesiologist;
AD - Medical Supervision by a physician; more than 4 concurrent anesthesia procedures;
G8 - Monitored anesthesia care (MAC) for deep complex complicated, or markedly invasive surgical procedures;
G9 - Monitored anesthesia care for patient who has a history of severe cardio-pulmonary condition;
QK - Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals;
QS - Monitored anesthesia care service The QS modifier is for informational purposes. Providers must report actual anesthesia time on the claim;
QX - CRNA service; with medical direction by a physician;
QY - Medical direction of one certified registered nurse anesthetist by an anesthesiologist;
QZ - CRNA service: without medical direction by a physician; and
GC - these services have been performed by a resident under the direction of a teaching physician. The GC modifier is reported by the teaching physician to indicate he/she rendered the service in compliance with the teaching physician requirements. One of the payment modifiers must be used in conjunction with the GC modifier.

§ 9789.17.7 Anesthesia – Personally Performed Rate

(a) Payment at Personally Performed Rate.

The anesthesia fee calculation will recognize the full base unit(s) for the anesthesia code and full time unit(s) in any of the following circumstances.

(1) The physician personally performed the entire anesthesia service alone.

(2) The physician is a teaching physician involved in the training of a resident in a single anesthesia case.

(3) The physician is a teaching physician involved in the training of residents in two concurrent anesthesia cases.

(4) The physician is a teaching physician involved in a single anesthesia case involving a resident that is concurrent to another case paid under the medical direction rules.

(5) The physician is continuously involved in a single case involving a student nurse anesthetist.

(6) The physician and the CRNA (or AA) are involved in one anesthesia case and the services of each are found to be medically necessary. Documentation must be submitted by both the CRNA and the physician to support payment of the full fee for each of the two providers. The physician reports the "AA" modifier and the CRNA reports the "QZ" modifier for a nonmedically directed case.

(b) To qualify for payment at the personally performed rate, the teaching anesthesiologist, or different anesthesiologists 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 physician'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 NPI of the teaching anesthesiologist who started the case must be indicated in the appropriate field on the billing form.
The teaching anesthesiologist should use the "AA" modifier and the "GC" certification modifier to report such cases.

9789.17.8 Anesthesia - Medically Directed Rate

(a) The anesthesia fee calculation for a physician involved in medically directed service will be made on the basis of 50 percent of the allowance for the service performed by the physician alone. Medical direction occurs if the physician medically directs qualified individuals in two, three, or four concurrent cases and the physician performs all of the following activities:

(1) Performs a pre-anesthetic examination and evaluation;

(2) Prescribes the anesthesia plan;

(3) Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence;

(4) Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist;

(5) Monitors the course of anesthesia administration at frequent intervals;

(6) Remains physically present and available for immediate diagnosis and treatment of emergencies; and

(7) Provides indicated-post-anesthesia care.

(b) The physician performing medically directed service must document in the medical record that he or she performed the pre-anesthetic examination and evaluation. Physicians must also document that they provided indicated post-anesthesia care, were present during some portion of the anesthesia monitoring, and were present during the most demanding procedures, including induction and emergence, where indicated.

(c) 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.
(d) The medical direction rules do not apply to a single resident case that is concurrent to another anesthesia case paid under the medical direction rules or to two concurrent anesthesia cases involving residents.
(e) If anesthesiologists are in a group practice, one physician member may provide the pre-anesthesia examination and evaluation while another fulfills the other criteria. Similarly, 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 services were furnished by physicians and identify the physicians who furnished them.
(f) 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 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. 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 fee schedule payment. 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.
(g) Concurrency is defined with regard to the maximum number of procedures that the physician is medically directing within the context of a single procedure and whether these other procedures overlap each other.

§9789.17.9 Anesthesia - Medically Supervised Rate

The maximum fee when the anesthesiologist is involved in furnishing more than four procedures concurrently, or is performing other services while directing the concurrent procedures, is three base units per procedure. An additional time unit may be recognized if the physician can document that he or she was present at induction.

§9789.17.10 Anesthesia - Multiple Anesthesia Procedures

(a) Physicians and non-physician providers shall bill for the anesthesia services associated with multiple bilateral surgeries by reporting the anesthesia procedure with the highest base unit value with the multiple procedure modifier "-51." The total time for all procedures shall be reported in the line item with the highest base unit value.
(b) If the same anesthesia CPT code applies to two or more of the surgical procedures, billers enter the anesthesia code with the "-51" modifier and the number of surgeries to which the modified CPT code applies.
(c) Payment can be made under the fee schedule for anesthesia services associated with multiple surgical procedures or multiple bilateral procedures. The maximum fee is determined based on the base unit of the anesthesia procedure with the highest base unit value and time units based on the actual anesthesia time of the multiple procedures.

§9789.17.11 Anesthesia - Medical and Surgical Services Furnished in Addition to Anesthesia Procedure

Payment may be made under the fee schedule for specific medical and surgical services furnished by the anesthesiologist as long as these services are reasonable and medically necessary and provided that other bundling and ground rule provisions do not preclude separate payment. These services may be furnished in conjunction with the anesthesia procedure to the patient or may be furnished as single services, e.g., during the day of or the day before the anesthesia service. These services include the insertion of a Swan Ganz catheter, the insertion of central venous pressure lines, emergency intubation, and critical care visits.

§9789.17.12 Anesthesia - Monitored Anesthesia Care

The physician or non-physician provider shall be reimbursed for reasonable and medically necessary monitored anesthesia care services on the same basis as other anesthesia services. Anesthesiologists use modifier QS to report monitored anesthesia care cases. Monitored anesthesia care involves the intra-operative monitoring by a physician or qualified individual under the medical direction of a physician or of the patient's vital physiological signs in anticipation of the need for administration of general anesthesia or of 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, valium) and provision of indicated postoperative anesthesia care.
Payment is made under the fee schedule using the payment rules in section 9789..17.7 if the physician personally performs the monitored anesthesia care case or under the rules in section 9789.17.8 if the physician medically directs four or fewer concurrent cases and monitored anesthesia care represents one or more of these concurrent cases.

§9789.17.13 Anesthesia and Medical/Surgical Service Provided by the Same Physician

(a) CPT codes 99143 to 99145 for moderate sedation provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, shall be billed "By Report" as long as the diagnostic or therapeutic service is billed is not listed in Appendix G of CPT, and is not otherwise inappropriate under Physician Fee Schedule ground rules. The moderate (conscious) sedation codes are carrier priced under the Medicare physician fee schedule.
(b) If the physician or CRNA provides anesthesia for diagnostic or therapeutic nerve blocks or injections and a different provider performs the block or injection, then the physician or CRNA may report the anesthesia service using CPT code 01991. The service must meet the criteria for monitored anesthesia care. If the physician or CRNA provides both the anesthesia service and the block or injection, then the physician 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 billing conscious sedation and if a lower level complexity anesthesia service is provided, then the conscious sedation code should not be reported.
(c) If the physician performing the medical or surgical procedure also provides a level of anesthesia lower in intensity than moderate or conscious sedation, such as a local or topical anesthesia, then the conscious sedation code should not be reported and no payment is allowed.

§9789.17.4 Anesthesia – Local

There is no CPT code for the performance of local or topical anesthesia as payment for this service is considered to be bundled into the payment for the underlying medical or surgical service.

§9789.18.1 Radiology –Diagnostic Imaging Multiple Procedures

(a) Where a procedure is designated with a "4" in Multiple Procedure Column Y of the CMS National Physician Fee Schedule Relative Value excel file, special rules apply for the technical component of the diagnostic imaging procedure if the procedure is billed with another diagnostic imaging procedure in the same family (Diagnostic Imaging Family Indicator is in Column AH.) If the procedure is reported in the same session on the same day as another procedure with the same family indicator, rank the procedures by fee schedule amount for the TC. Maximum fee shall be: 100% for the highest priced procedure, and 75% for each subsequent procedure.

(b) Diagnostic Imaging Family Indicators are as follows:

01=	Ultrasound (Chest/Abdomen/Pelvis-Non-Obstetrical)
02=	CT and CTA (Chest/Thorax/Abd/Pelvis)
03=	CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck)
04=	MRI and MRA (Chest/Abd/Pelvis)
05=	MRI and MRA (Head/Brain/Neck)
06=	MRI and MRA (Spine)
07=	CT (Spine)
08=	MRI and MRA (Lower Extremities)

09=	CT and CTA (Lower Extremities)
10=	MR and MRI (Upper Extremities and Joints)
11=	CT and CTA (Upper Extremities)
99=	Concept does not apply

(c) The multiple diagnostic imaging procedure discount is applied to the technical component only; it does not apply to the professional component (PC).