moda HEALTH	Reimbursement Policy Manual	Policy #:	RPM031
Policy Title:	Modifier 47 - Anesthesia By Surgeon		
Section:	Anesthesia	Subsection:	Modifiers

Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:

Companies:	☒ All Companies: Moda Partners, Inc. and its subsidiaries & affiliates ☐ Moda Health Plan ☐ Moda Assurance Company ☐ Summit Health Plan ☐ Eastern Oregon Coordinated Care Organization (EOCCO) ☐ OHSU Health IDS
Types of Business:	☒ All Types ☐ Commercial Group ☐ Commercial Individual ☐ Commercial Marketplace/Exchange ☐ Commercial Self-funded ☐ Medicaid ☐ Medicare Advantage ☐ Short Term ☐ Other: _____
States:	☒ All States ☐ Alaska ☐ Idaho ☐ Oregon ☐ Texas ☐ Washington
Claim forms:	☒ CMS1500 ☐ CMS1450/UB (or the electronic equivalent or successor forms)
Date:	☒ All dates ☐ Specific date(s): _____ ☐ Date of Service; For Facilities: ☐ n/a ☐ Facility admission ☐ Facility discharge ☐ Date of processing
Provider Contract Status:	☒ Contracted directly, any/all networks ☒ Contracted with a secondary network ☒ Out of Network

Originally Effective:	1/1/2000	Initially Published:	8/14/2013
Last Updated:	7/13/2022	Last Reviewed:	7/13/2022
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)?		No	
Last Update Effective Date for Texas:		7/13/2022	

Reimbursement Guidelines

Anesthesia provided by the surgeon is included in the global allowance for the surgical procedure. No additional allowance is made for the use of modifier 47.

Separate reporting for moderate conscious sedation services (CPT codes 99151-99152) is allowed when provided by same physician performing a medical or surgical procedure. Separate reimbursement for moderate conscious sedation depends upon whether or not the fee allowance for the claim is based upon a 2017 or later fee schedule, and which surgical codes are reported. For more information, see "Moderate (Conscious) Sedation." Moda Health Reimbursement Policy Manual, RPM048.

The use of modifier 47 does not bypass any bundling or clinical editing.

Modifier 47 is considered invalid when appended to CPT codes describing anesthesia services (00100-01999).

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation		Definition
AMA	=	American Medical Association
CCI	=	Correct Coding Initiative (see "NCCI")
CMS	=	Centers for Medicare and Medicaid Services
CPT	=	Current Procedural Terminology
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	=	Health Insurance Portability and Accountability Act
MS DRG	=	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	=	National Correct Coding Initiative (aka "CCI")
OPPS	=	Outpatient Prospective Payment System
RPM	=	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
UB	=	Uniform Bill

Modifier Definitions:

Modifier	Modifier Description & Definition
Modifier 47	**Anesthesia by Surgeon:** Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia.) **Note:** Modifier 47 would not be used as a modifier for the anesthesia procedures.

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

"Medicare Anesthesia Rules prevent separate payment for anesthesia services by the same physician performing a surgical or medical procedure. The physician performing a surgical or medical procedure should not report CPT codes 96360-96376 for the administration of anesthetic agents during the procedure. If it is medically reasonable and necessary that a separate provider (anesthesia practitioner) perform anesthesia services (e.g., monitored anesthesia care) for a surgical or medical procedure, a separate anesthesia service may be reported by the second provider." (*CMS*[1])

"Under OPPS, anesthesia for a surgical procedure is an included service and is not separately reportable. For example, a provider should not report CPT codes 96360-96376 for anesthesia services." (*CMS*[1])

"When anesthesia services are not separately reportable, physicians and facilities should not unbundle components of anesthesia and report them in lieu of an anesthesia code." (*CMS*[1])

"Under the CMS Anesthesia Rules, with limited exceptions, Medicare does not allow separate payment for anesthesia services performed by the physician who also furnishes the medical or surgical service. In this case, payment for the anesthesia service is included in the payment for the medical or surgical procedure. For example, separate payment is not allowed for the physician's performance of local, regional, or most other anesthesia including nerve blocks if the physician also performs the medical or surgical procedure. However, Medicare allows separate reporting for moderate conscious sedation services (CPT codes 99143-99145) when provided by same physician performing a medical or surgical procedure except for those procedures listed in Appendix G of the *CPT Manual*." (*CMS*[2])

"CPT codes describing anesthesia services (00100-01999) or services that are bundled into anesthesia should not be reported in addition to the surgical or medical procedure requiring the anesthesia services if performed by the same physician." (*CMS*[2])

The physician performing a surgical or medical procedure should not report an epidural/subarachnoid injection (CPT codes 62310- 62319) or nerve block (CPT codes 64400-64530) for anesthesia for 62319) or nerve block (CPT codes 64400-64530) for anesthesia for that procedure." (*CMS*[2])

"Postoperative pain management services are generally provided by the surgeon who is reimbursed under a global payment policy related to the procedure and shall not be reported by the anesthesia practitioner unless separate, medically necessary services are required that cannot be rendered by the surgeon. The surgeon is responsible to document in the medical record the reason care is being referred to the anesthesia practitioner." (*CMS*[3])

Cross References

"Moderate (Conscious) Sedation." Moda Health Reimbursement Policy Manual, RPM048.

References & Resources

1. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, § C, 2.

2. CMS. "Anesthesia Service Included in the Surgical Procedure." *National Correct Coding Initiative Policy Manual*. Chapter 1 General Correct Coding Policies, § G.

3. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 2 Anesthesia Services, § B, 3.

4. American Medical Association. "Summary of CPT Codes That Include Moderate (Conscious) Sedation." *Current Procedural Terminology (CPT), Appendix G*. Chicago: AMA Press. .

Background Information

Modifiers are two-character suffixes (alpha and/or numeric) that are attached to a procedure code. CPT modifiers are defined by the American Medical Association (AMA). HCPCS Level II modifiers are defined by the Centers for Medicare and Medicaid Services (CMS). Like CPT codes, the use of modifiers requires explicit understanding of the purpose of each modifier.

Modifiers provide a way to indicate that the service or procedure has been altered by some specific circumstance but has not been changed in definition or code. Modifiers are intended to communicate specific information about a certain service or procedure that is not already contained in the code definition itself. Some examples are:

- To differentiate between the surgeon, assistant surgeon, and facility fee claims for the same surgery
- To indicate that a procedure was performed bilaterally
- To report multiple procedures performed at the same session by the same provider
- To report only the professional component or only the technical component of a procedure or service
- To designate the specific part of the body that the procedure is performed on (e.g., T3 = Left foot, fourth digit)
- To indicate special ambulance circumstances

More than one modifier can be attached to a procedure code when applicable. Not all modifiers can be used with all procedure codes.

Modifiers do not ensure reimbursement. Some modifiers increase or decrease reimbursement; others are only informational.

Modifiers are not intended to be used to report services that are "similar" or "closely related" to a procedure code. If there is no code or combination of codes or modifier(s) to accurately report the service that was performed, provide written documentation and use the unlisted code closest to the section which resembles the type of service provided to report the service.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member's medical benefit plan, the member's medical

benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
7/13/2022	Formatting/Update: Change to new header. Acronym table: 7 entries added. Policy History section: Added. Entries prior to 2022 omitted (in archive storage).
8/14/2013	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
1/1/2000	Original Effective Date (with or without formal documentation). Policy based on CMS policy for anesthesia performed by the surgeon.