Perioperative Charge Process

November 2025

Perioperative Charge Process

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Perioperative Charge Process

Introduction

The charge process for surgical services includes eight components:

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6. Supplies
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Below is a summary of how each of these components applies to charging for surgical services.

Pre-Operative Care

The pre-operative care includes the starting of IVs, administration of drugs, scrubbing and shaving of the patient. Pre-operative antibiotic IV therapy is separately reportable as a nursing service if there is medical justification and a physician order.

It is not appropriate to charge for pre-operative care, the majority of hospitals have a cost center dedicated to this process; zero charges are used for the recording of workload.

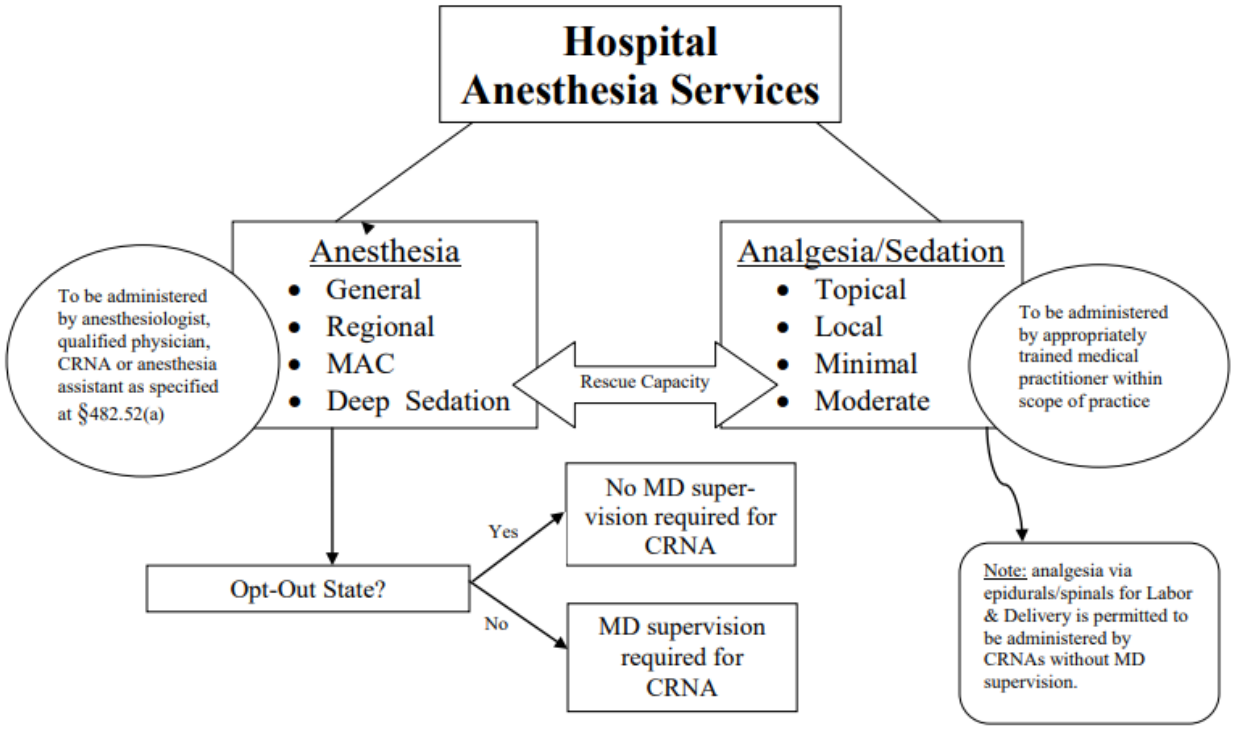
Procedure Description	Exc	Qty	Price	CPT® /HCPCS				Revenue Code		
				CPT	HCPCS	HCPCS2	Other	UBDFLT	OPPS	Part B Only
OP SURGERY CARE	-	151	-					0369		

Anesthesia

There are eight different types of anesthesia:

1. Local
2. Block
3. Epidural
4. Moderate Sedation
5. Monitored Anesthesia Care
6. TIVA
7. General
8. General with Block

R59SOMA – Clarification of the Interpretive Guidelines for the Anesthesia Services Condition of Participation



Who may administer the various Anesthesia types?

Topical/local anesthetics, minimal sedation, moderate sedation:

The requirements concerning who may administer anesthesia do not apply to the administration of topical or local anesthetics, minimal sedation, or moderate sedation. However, the hospital must have policies and procedures, consistent with the State scope of practice law, governing the provision of these types of anesthesia services. Further, hospitals must ensure that all anesthesia services are provided in a safe, well-organized manner by qualified personnel.

General anesthesia, regional anesthesia and monitored anesthesia, including deep sedation/analgesia, may only be administered by:

- A qualified anesthesiologist;
- An MD or DO (other than anesthesiologist);
- A dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law;

- A CRNA who is supervised by the operating practitioner or by an anesthesiologist who is immediately available if needed; or
- An anesthesiologist's assistant under the supervision of an anesthesiologist who is immediately available if needed.

Charging for Anesthesia Services

Anesthesia services can be either charged individually for supplies, drugs, and gases, but more common is a time-based charge for the type of anesthesia provided. Some managed care contracts do not allow the combination of both an itemized anesthesia service and a time-based charge.

Timing of anesthesia (CS, MAC, and General) charges is based on the start/stop times recorded on the anesthesia record. The base time period is 30 minutes, with an add-on charge for each additional 15 minutes. Add-on periods are charged after the first five minutes of usage within the period.

Procedure Description	Exc	Qty	Price	CPT® /HCPCS				
				CPT	HCPCS	CPT4 Me...	Other	REVENUE
Local/Sedation	-	2,090	51.00					0370
Local/Sedation addl	-	2,156	6.00					0370
Local	-	39	51.00					0370
Local addl	-	44	8.00					0370
General	-	4,869	960.00					0370
General addl	-	30,094	231.00					0370
MAC	-	2,618	361.00					0370
MAC addl	-	2,966	121.00					0370
Axillary Block	-	1,013	240.00					0370
Axillary Block addl	-	6,161	58.00					0370

Anesthesia Modifiers

Anesthesiologist Modifiers

Modifier	Description
AA	Anesthesia Services performed personally by the anesthesiologist
AD	Medical Supervision by a physician; more than 4 concurrent anesthesia procedures

Modifier	Description
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals
QY	Medical direction of one qualified nonphysician anesthetist by an anesthesiologist
GC	Services performed by a resident under the direction of a teaching physician

Monitored Anesthesia Care (MAC)

Modifier	Description
QS	Monitored anesthesia care service
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

Note: the QS modifier can be used by a physician or a qualified nonphysician anesthetist and is for informational purposes. Providers must report actual anesthesia time and one of the payment modifiers on the claim.

CRNA Modifiers

Modifier	Description
QX	CRNA service; with medical direction by a physician.
QZ	CRNA service; without medical direction by a physician

For additional information on Physical Status Modifiers, see Novitas Anesthesia modifiers.

Assistant at Surgery/Co–Surgeon

Please see the Assistant at Surgery paper for additional guidance on Assistants at Surgery and Co-Surgeons, including usage of modifiers.

Operating Room Time Charges

The operating room costs are classified into three different components, which are relieved by billing a time-based level charge. The components of the OR room costs are:

1. Room Set-Up Time
2. Staff Surgical Time Charge (Nurses, Tech, and First Assistant) Charges
3. Rental/Special Equipment Charges

CorroHealth recommends that the OR time charge be based on levels which are determined by the set-up, staff, and equipment charges.

OR room time charges are based on the start/stop surgical time on the anesthesia record or "wheels in to wheels out." Add-on periods are charged after the first five minutes of usage within a period.

Procedure Description	Exc	Qty	Price	CPT® /HCPCS				
				CPT	HCPCS_O...	Medicaid	Other	Rev...
Or Level 1 1St 30 Mi	-	20	2,297.00					0360
Or Level 1 Addl 15M	-	31	229.00					0360
Or Level 2 1St 30 Min	-	539	3,063.00					0360
Or Level 2 Addl 15M	-	77	307.00					0360
Or Level 3 1St 30 Mi	-	2,369	5,106.00					0360
Or Level 3 Addl 15M	-	3,128	510.00					0360
Or Level 4 1St 30 Min	-	6,437	8,509.00					0360
Or Level 4 Addl 15M	-	37,217	852.00					0360
OR Level MINOR 1st 30 Min	-	-	2,770.00					0360
OR Level MINOR Addl 15 Min	-	-	260.00					0360
OR Level MAJOR 1st 30 Min	-	-	6,900.00					0360
OR Level MAJOR Addl 15 Min	-	-	750.00					0360

Equipment Charges

Special and rental equipment are usually "packaged" into the OR room time charge by "bumping" a level, some Fiscal Intermediaries will allow the billing of equipment charges on an OR line on the UB04 claim form using revenue code 0360.

When determining the additional charges associated with new equipment, the following calculations can be used to ensure the cost of the equipment is factored into the cost of a procedure.

Cost Basis Charge Calculation		Market Basis Charge Calculation		Additional Cost Considerations
Capital Item Purchase Cost (include tax, shipping)	165,000	Geographic Peer Group Average Charge		Rental Cost
Useful Life Years (Standard is 5)	5	State Average Charge		Inpatient vs Outpatient
Residual Value (Standard is Zero)	0	National Average Charge		Packaged Services
Annual Depreciation Cost	33,000			Supplies
Annual Maintenance Cost	8,250	**Reimbursement Basis Charge Calculation**		Medications
Annual Expected Number of Procedures	255	APC Reimbursement	1.00	Payroll
Equipment Cost per Procedure	**162**	**Projected Cange of Charge per Procedure (3x) - Low**	**3.00**	Procedure Room
Expected Average Staff Time per Procedure (Minutes)	0	**Projected Range of Charge per Procedure (5x) - High**	**5.00**	Pre/Post Procedure
Average Staff Labor Cost per Hour	35			Anesthesia
Average Staff Benefit Cost (percent add-on)	20%	**Charge per Procedure**		Recovery
Staff Cost per Procedure	**0**			
Disposable Supply Cost per Procedure	500			
Total Cost per Procedure	**662**			
Projected Range of Charge per Procedure (3x) - Low	**1,985.29**			
Projected Range of Charge per Procedure (5x) - High	**3,308.82**			

Recovery/Post-Anesthesia Care Unit Charges

The required time a patient spends in the PACU is one hour for general anesthesia, with a nurse-to-patient ratio of 1:1. After the patient is attended for a minimum period and the nurse assessment determines the patient requires a lower staffing ratio, a nurse can attend to two patients. However, the American Society of PeriAnesthesia Nurses (ASPAN) Practice Recommendation Patient Classification / Staffing Recommendations for Phase I recovery for MAC anesthesia types, which indicates that the best practice is a 1:2 Nurse-to-Patient Ratio.

MAC anesthesia patients are to be observed for a minimum of 30 minutes.

Children are typically 2:1 Nurse-to-Patient ratio.

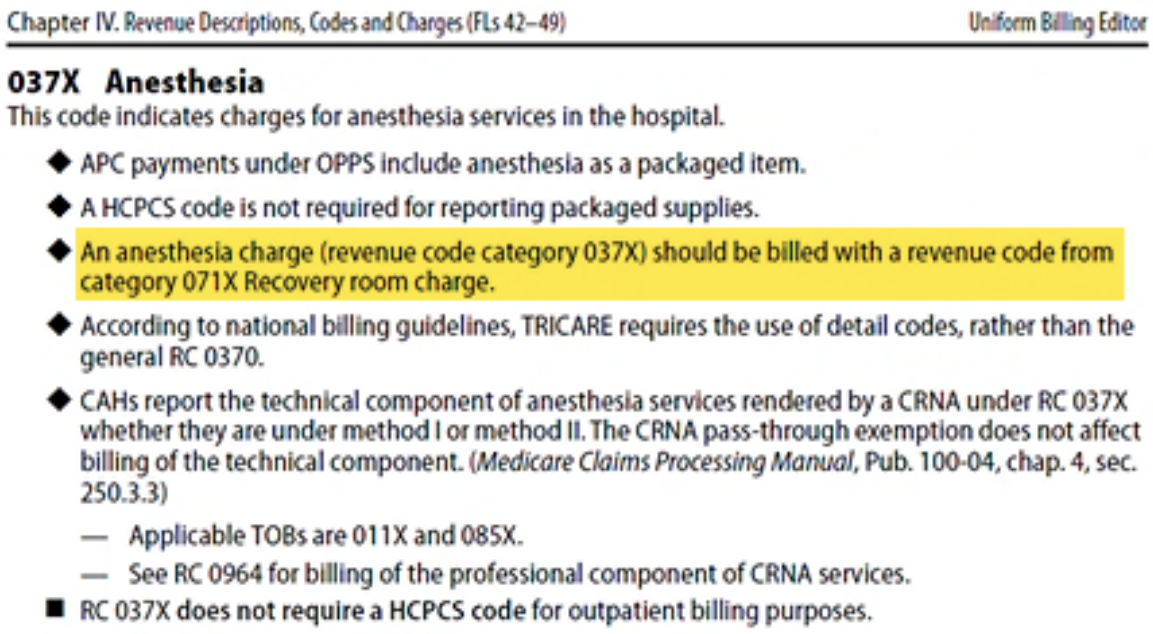
Charges for PACU may be set as follows:

1. PACU- 1st hour 1:1 ratio
2. PACU- additional 15 minutes 1:1 ratio
3. PACU- additional 15 minutes 1:2 ratio

However, it is also appropriate to charge by the minute. Timing of the PACU charges are based on the PACU admit/discharge times recorded on the PACU record.

Procedure Description	Exc	Qty	Price	CPT® /HCPCS				Revenue Code		
				CPT	HCPCS	CPT4 Me...	Other	REVENUE	MEDICAR...	MEDICAR...
Acuity Level I	-	3,904	778.00					0710		
Acuity Level I addl	-	9,778	156.00					0710		
Acuity Level II	-	1,485	1,088.00					0710		
Acuity Level II addl	-	3,473	312.00					0710		
Acuity Level III	-	2,675	1,249.00					0710		
Acuity Level III addl	-	9,556	312.00					0710		
Acuity Level IV	-	260	1,709.00					0710		
Acuity Level IV addl	-	1,884	312.00					0710		

Recovery room services under revenue code 0710 should be reported on the same claim as anesthesia services using revenue code 037X. This is because the revenue code 0710 is designated for post-anesthesia recovery services. If no anesthesia were administered during the procedure, it would not be appropriate to also charge for recovery room services.



Chapter IV. Revenue Descriptions, Codes and Charges (FLs 42–49) Uniform Billing Editor

037X Anesthesia

This code indicates charges for anesthesia services in the hospital.

- APC payments under OPPS include anesthesia as a packaged item.
- A HCPCS code is not required for reporting packaged supplies.
- An anesthesia charge (revenue code category 037X) should be billed with a revenue code from category 071X Recovery room charge.
- According to national billing guidelines, TRICARE requires the use of detail codes, rather than the general RC 0370.
- CAHs report the technical component of anesthesia services rendered by a CRNA under RC 037X whether they are under method I or method II. The CRNA pass-through exemption does not affect billing of the technical component. (*Medicare Claims Processing Manual*, Pub. 100-04, chap. 4, sec. 250.3.3)
  - Applicable TOBs are 011X and 085X.
  - See RC 0964 for billing of the professional component of CRNA services.
- **RC 037X does not require a HCPCS code for outpatient billing purposes.**

Anthem has been updating its policies to align with industry-standard guidelines, such as the **Uniform Billing Editor** (see above), to deny claims with revenue code 0710 (recovery room services) when revenue code 0370 (anesthesia services) is not reported. See Recovery room

— facility editing effective for claims on or after August 1, 2024, and Outpatient facility editing system update for recovery room claims effective for claims on or after November 1, 2025.

Medical Supplies

There are seven types of supplies used in the OR, some of which should not be charged to the patient. The various types of supplies and the billing status for each are as follows:

1. *Routine items*- Low cost, bulk stock items (i.e., Band-Aids, syringes, wipes, gowns, gloves, drapes, and packs) are not to be charged. The cost is to be billed using the OR time charge.
2. *Sterile*- Higher cost items are itemized on the charge form; multiple units are allowed. These items are to be billed with an HCPCS code (if possible) and 0272 revenue code.
3. *DME exempt*- These are DME items which can be billed to the Medicare program, they include orthotics (splints, braces, collars, and belts). These items are billed using a HCPCS code and a 0274 revenue code.
4. *DME non-exempt*- Non-billable DME items (i.e., crutches, canes, and walkers) are not to be billed to the Medicare program on a bill type UB04.
5. *Implants*- Hard items which remain in the patient post-procedure, these items may have a HCPCS code and are billed using a 0278 revenue code.
6. *IOL Lenses*- Billed using a HCPCS code (if possible) and a 0276 revenue code. High cost lenses can be billed to the patient (lens cost less the $150 Medicare allowance).
7. *Pacemakers*- Requires a HCPCS code and a 0275 or 0278 revenue code.

From the Official UB-04 Data Specifications Manual 2026:

FORM LOCATOR 42

Effective Date: July 1, 2020 **Meeting Date:** 8/14/19, 4/8/20

027x **Medical/Surgical Supplies and Devices (also see 062x, an extension of 027x)**

Charges for supply items required for patient care.

Sub C	Subcategory Definition	Standard Abbreviation	Unit	HCPCS
0	General Classification	MED-SUR SUPPLIES		
1	Non-sterile Supply	NON-STER SUPPLY		
2	Sterile Supply	STERILE SUPPLY		
3	Take Home Supplies	TAKEHOME SUPPLY		
4	Prosthetic/Orthotic Devices	PROSTH/ORTH DEV	Devices	
5	Pacemaker	PACEMAKER		
6	Intraocular Lens	INTRA OC LENS		
7	Oxygen - Take Home	02/TAKEH0ME		
8	Other Implant	SUPPLY/IMPLANTS		Y
9	Other Supplies/Devices	SUPPLY/OTHER		

Notes: Revenue codes 0274, 0275 and 0276 identify specific types of implants. Other Implants are reported under 0278.

Implantables: That which is implanted, such as a piece of tissue, a tooth, a pellet of medicine, a tube or needle containing a radioactive substance, a graft, or an insert. Also included are liquid and solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed, stents, artificial joints, shunts, pins, plates, screws, and anchors.

Hospitals should be cautious when billing for supplies. Medicare considers some supplies routine and not separately billable, others are covered, billable, and payable, and some are covered and billable but packaged and not separately paid.

The following criteria should be met to determine when to separately bill for supplies according to the Medicare Provider Reimbursement Manual, Chapter 22 – Determination of Cost of Services, Section 2202.6:

2202.6 Routine Services.--Inpatient routine services in a hospital or skilled nursing facility generally are those services included in by the provider in a daily service charge--sometimes referred to as the "room and board" charge. Routine services are composed of two board components; (1) general routine services, and (2) special care units (SCU's), including coronary care units (CCU's) and intensive care Units (ICU's). Included in routine services are the regular room, dietary and nursing services, minor medical and surgical supplies, medical social services, psychiatric social services, and the use of certain equipment and facilities for which a separate charge is not customarily made.

Examples of routine services include:

- Personal convenience items such as slippers, lotions, powder, gowns, and towels
- Items not used specifically on the patient, such as staff gowns, masks, and gloves
- Basic medical supplies, such as cotton balls, non-specialized bandaging, alcohol wipes, gauze, and adhesive tape
- General-use equipment/supplies including urinals, bedpans, emesis basins, and tourniquets
- Bulk items and items provided or used on most patients in the same setting, such as non-specialized irrigation solutions, ice packs, blood pressure cuffs, thermometers, diapers, soap, tubing, and prep kits.

There is no all-inclusive list of billable supplies. Facilities must create a process to use in determining the billable status of a supply that is used for all supply items. As with any billable item, documentation and medical necessity must be substantiated in the patient's medical record. For additional guidance, see Billing for Supplies.

Drugs

All drugs are to be charged; multiple units allowed. The nursing service to administer the drugs is **not** reportable.

Procedure Description	Exc	Qty...	Price	CPT® /HCPCS			Revenue Code		
					HCPCS_O...	Me...	Other	Rev...	Rev...	Part B
76045-0106-10 - dexAMETHasone 20mg/5mL (4...	-	1,383	49.00		J1100			0250	0636	
63323-0288-20 - ANES ropivacaine 1% SDV 200...	-	1,311	144.00		J2795			0250	0636	
63323-0492-36 - ANES lidocaine 1% 5mL SDV M...	-	1,189	22.00		J2003			0250	0636	
00143-9983-03 - ceFAZolin 10 g Powder Injectio...	-	1,117	69.00		J0690			0250	0636	
00409-4279-02 - ANES lidocaine 1% 30mL SDV ...	-	900	19.00		J2003			0250	0636	
00409-1163-01 - ANES bupivacaine 0.5% 50mL ...	-	854	16.00		J0665			0250	0636	
55150-0194-10 - ANES esmolol 100mg/10mL (1...	-	758	46.00		J1805			0250	0636	
70121-1049-02 - triamcinolone acet. 40mg/1mL ...	-	745	53.00		J3301			0250	0636	
00409-1559-30 - ANES bupivacaine 0.25% 30mL...	-	645	24.00		J0665			0250	0636	
00075-0620-40 - enoxaparin 40 mg/0.4 mL Sub...	-	643	208.00		J1650			0250	0636	
00781-3290-09 - Clindamycin 900mg/50mL Pre...	-	560	95.00		J0736			0250	0636	
00409-1176-30 - meperidine 25 mg/mL Inj Sol [...	-	536	39.00		J2175			0250	0636	
60505-6130-05 - ondansetron 4mg/2mL (2 mg/...	-	536	6.00		J2405			0250	0636	
00641-6125-25 - morphine 4 mg/mL (1mL) Pres...	-	477	16.00		J2270			0250	0636	
00409-1890-01 - morphine 2 mg/mL (1mL) Pres...	-	444	14.00		J2270			0250	0636	
00409-9094-25 - ANES fentaNYL 250mcg/5mL (...	-	388	7.00		J3010			0250	0636	

Post PACU Care

Routine care provided to a patient post-PACU and prior to discharge is **not** separately reportable to the Medicare program.

CMS IOM Pub. 100-04 Medicare Claims Processing Manual, Chapter 4, section 290.2.2

290.2.2 - Reporting Hours of Observation
(Rev. 2234, Issued: 05-27-11, Effective: 07-01-11, Implementation: 07-05-11)

Observation time begins at the clock time documented in the patient's medical record, which coincides with the time that observation care is initiated in accordance with a physician's order. Hospitals should round to the nearest hour. For example, a patient who began receiving observation services at 3:03 p.m. according to the nurses' notes and was discharged to home at 9:45 p.m. when observation care and other outpatient services were completed, should have a "7" placed in the units field of the reported observation HCPCS code.

General standing orders for observation services following all outpatient surgery are not recognized. Hospitals should not report as observation care, services that are part of another Part B service, such as postoperative monitoring during a standard recovery period (e.g., 4-6 hours), which should be billed as recovery room services. Similarly, in the case of patients who undergo diagnostic testing in a hospital outpatient department, routine preparation services furnished prior to the testing and recovery afterwards are included in the payments for those diagnostic services.

Observation services should not be billed concurrently with diagnostic or therapeutic services for which active monitoring is a part of the procedure (e.g., colonoscopy, chemotherapy). In situations where such a procedure interrupts observation services, hospitals may determine the most appropriate way to account for this time. For example, a hospital may record for each period of observation services the beginning and ending times during the hospital outpatient encounter and add the length of time for the periods of observation services together to reach the total number of units reported on the claim for the hourly observation services HCPCS code G0378 (Hospital observation service, per hour). A hospital may also deduct the average length of time of the interrupting procedure, from the total duration of time that the patient receives observation services.

Example Perioperative Charge Process Point System

CorroHealth recommends creating a point system for OR, Anesthesia, and PACU level determinations. Below is an example of a recommended point system.

Perioperative Charge Process

Perioperative Charge Process Point System

Pre/Post PACU + Set-up Time - Minutes	Points	Operating Rooms Staff	Points	Extensive Equipment Use	Points
<30	0	1	1	Yes	1
31 -> 90	1	2	2	No	0
91 -> 120	2	3	3		
		4	4		
		5	5		
OR Level Determination	# of Pts				
Pre / Post / SU					
OR Staff					
Equipment					
Total					
OR Level Points	1st Hour time charge	Additonal 1/4 time charge			
1					
2					
3					
4					
5					
6					
7					
Anesthesia Type	Time Basis	1st Hour / Initial Procedure	Additional 1/4 Hours / Subsequent procedures		
General	Elapsed time				
TIVA	Elapsed time				
MAC	Elapsed time				
IV Sedation	Elapsed time				
Epidural	One time		N/A		
Block	One time		N/A		
Local	One time		N/A		
Pain	Per Injection				
N/A					
PACU - Nurse Patient Ratio	1st Hour time charge	Additional 1/4 time charge			
1:1					
1:2					
ICU Holding					

References

- Billing for Supplies
- Observation – Charging, Billing, Compliance and Reimbursement
- AANA – Anesthesia Billing Basics Considerations Checklist
- Q&A – Recovery Room Services