Anthem Blue Cross and Blue Shield
Professional Reimbursement Policy

Subject: Anesthesia Services	
IN, KY, MO, OH, WI Policy: 0020	**Effective: 07/01/2015 – 04/30/2017**

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Description

Anesthesia describes the loss of sensation resulting from the administration of a pharmacologic agent that blocks the passage of pain impulses along nerve pathways to the brain. There are many types of anesthesia, but the three major types are:

General----anesthesia affecting the entire body and accompanied by a loss of consciousness.
Regional---loss of all forms of sensation of a particular region of the body.
Local-------loss of sensation in a limited and superficial (i.e. surface) area of the body.

Services involving the administration of anesthesia are reported by using the anesthesia five digit *Current Procedural Terminology* (CPT®′) procedure code (00100-01999) and, if applicable, a physical status modifier and/or a servicing modifier.

The Health Plan uses a number of factors in determining the reimbursement amount for a particular anesthesia service. Some of the factors that the Health Plan uses, in combination or separately, are:

- Base Units (BU)----------are assigned to a specific anesthesia CPT code and are derived from the American Society of Anesthesiologists (ASA) Anesthesia Relative Value Guide (RVG™″)
- Time Units (TU)----------a time unit is equal to 15 minutes
- Conversion Factors (CF)--is a single unit rate used in the calculation for anesthesia reimbursement
- Modifiers----------are to identify servicing and physical status
- Additional Factors---------such as qualifying circumstances, field avoidance, or unusual positioning

Policy

I. Time

- Anesthesia time begins when the individual who administers the anesthesia begins to prepare the patient for anesthesia care in the operating room or in the equivalent area, and ends when such individual is no longer in personal attendance and is no longer providing anesthesia services. Anesthesia time can be counted in blocks of time if there is an interruption in anesthesia, as long as the time counted is that in which continuous anesthesia services are provided.

- Based on ASA billing guidelines, when anesthesia services are provided for multiple surgical procedures, only the anesthesia procedure code for the most complex service should be reported. Base units are only used for the primary procedure and not for any secondary procedures. If two separate anesthesia codes are reported, the procedure with the lesser charge will be denied. (Exception: Add-on codes 01953, 01968, or 01969, which are listed separately in addition to the code for the primary procedure, are eligible for separate reimbursement.)

- If the Health Plan can determine, based on its review of the anesthesia record, that a separate subsequent operative session took place with more than an hour separation from the initial anesthesia, the second subsequent anesthesia service may be considered eligible for separate reimbursement.**

  ** This unique situation may occur due to a complication creating an emergency situation necessitating a return to the operating room; or, when two distinct conditions are treated and services are rendered in separate service sites.

- Time spent performing anesthesia services is reported in one minute increments and noted in the unit's field. To calculate reimbursement for time, the number of minutes reported is divided by 15 (minutes) and rounded up to the next tenth to provide a unit of measure.**
  **Example: 61 minutes divided by15 = 4.0666 units. Reimbursement for time will be rounded to 4.1 units instead of using a whole 5 unit of measure.

- The maximum allowance for reimbursement of anesthesia services rendered is calculated by adding the time units to the base units assigned to the anesthesia code reported and multiplying that sum by the contracted conversion factor.**
  **In the example given above the time units would be 4.1. If the anesthesia code had a base unit of 5, then 4.1 added to 5 would give a reimbursement measure of 9.1. If the anesthesia allowance was $50, then 9.1 x $50 would =$455

II. Modifiers

a. Servicing Modifiers

- Claims for anesthesia should identify when a physician/anesthesiologist (MD) or non-physician anesthesia provider rendered the anesthesia services. Therefore, the Health Plan requires that a servicing modifier (as shown in the table below) must be appended to the reported anesthesia code.
- When a non-physician anesthesia provider bills for anesthesia administration, and a physician/anesthesiologist bills for supervising the non-physician anesthesia provider, services are eligible for reimbursement to both the supervising physician/anesthesiologist and the administering non-physician anesthesia provider according to the appropriate modifier and rate listed in the modifier table below.

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- Total reimbursement for anesthesia services provided by a physician/anesthesiologist and a non-physician anesthesia provider will not exceed the reimbursement that would have been allowed had the anesthesia service been provided by only the physician/anesthesiologist.
- The following table identifies servicing modifiers and indicates the applicable reimbursement percentage of the maximum allowance for such servicing modifier.

Modifier	Description	Reimbursement Percentage of maximum allowance
AA	Anesthesia services personally performed by anesthesiologist	100%
AD	Medical supervision by a physician: more than 4 concurrent anesthesia procedures	3 base units. This rate is determined by the Conversion Factor x 3 regardless of the base units for the procedure reported. No additional units are allowed such as those for physical status modifiers (P3, P4, and P5), qualifying circumstances, or time.
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals	50%
QX	CRNA with medical direction by a physician	50%
QY	Medical direction of one CRNA or AA by an anesthesiologist	50%
QZ	CRNA without medical direction by physician	100%

- The Health Plan requires that servicing modifiers AA, AD, QK, QX, QY, or QZ must be reported in the first modifier field of the claim line.
- Informational modifiers G8, G9, or QS may be reported in a subsequent modifier field when the service rendered is monitored anesthesia care (MAC).
- Please note, when modifier QK, QX or QY is appended to an applicable spinal/nerve injection code (e.g., 60000 series postoperative pain management/nerve block procedures), the reimbursement percentage of 50% will apply.

b. Physical Status Modifiers

Physical Status Modifiers identify a specific physical condition which indicates an added level of complexity to the anesthesia service provided. The Health Plan follows the ASA recommendation that unit values are assigned to the following physical status modifiers for additional reimbursement when appended to the base anesthesia code.

- Modifier P3 = *1 unit* (A patient with severe systemic disease)
- Modifier P4 = *2 units* (A patient with severe systemic disease that is a constant threat to life)
- Modifier P5 = *3 units* (A moribund patient who is not expected to survive without the operation)

The Health Plan does not recognize unit values for the following physical status modifiers, and no additional reimbursement is allowed.

- Modifier P1 = A normal, healthy patient
- Modifier P2 = A patient with mild systemic disease
- Modifier P6 = A declared brain-dead patient whose organs are being removed for donor purposes

In addition, the Health Plan follows the ASA RVG comment which states that a physical status modifier should not be reported with code 01996. Therefore, if the physical status payment modifier P3, P4, or P5 is appended to CPT 01996, the Health Plan will deny CPT 01996 due to the invalid modifier-procedure code combination.

c. Informational Modifiers:

- Modifier 47-- Anesthesia by Surgeon: Regional or general anesthesia provided by the surgeon may be reported by adding Modifier 47 to the basic service. Anesthesia services provided by the operating surgeon for a procedure are included in the global rate and are not reimbursed separately.
- Modifier 23-- Unusual Anesthesia: Occasionally a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This modifier does not affect the reimbursement for the reported anesthesia code.

III. Field Avoidance and Unusual Positioning

- **Field Avoidance:** The Health Plan allows the maximum allowance based on the published base unit values assigned by ASA to head, neck, and shoulder girdle anesthesia procedures regardless of field avoidance which may be required. Field avoidance is not eligible for additional reimbursement even when reported with modifier 22.

- **Unusual Positioning**: The Health Plan will reimburse the maximum allowance for any anesthesia procedure regardless of unusual positioning which may be required. Unusual positioning is not eligible for additional reimbursement.

IV. Qualifying Circumstances for Anesthesia

Sometimes anesthesia services are provided under difficult circumstances which may affect the condition of the patient, or present unusual operative conditions and/or risk factors. The following codes are used to identify these circumstances and are reported in addition to the anesthesia procedure or service provided.

- 99100 Anesthesia for patient of extreme age, younger than 1 year and older than 70
- 99116 Anesthesia complicated by utilization of the total body hypothermia
- 99135 Anesthesia complicated by utilization of controlled hypotension
- 99140 Anesthesia complicated by emergency conditions

These codes are eligible for separate reimbursement at the maximum allowance. The Health Plan uses its claims' editing system to determine when there may be a mutually exclusive relationship with the reported base anesthesia code.**

** **Note**: Based on the ASA RVG comment which states that "qualifying circumstances codes (+99100 through +99140) should not be reported with 01996,"[1] the Health Plan will deny the qualifying circumstances code(s) 99100, 99116, 99135, or 99140 as mutually exclusive if billed with 01996 (daily hospital management of epidural or subarachnoid continuous drug administration).

CPT 99140 is eligible for separate reimbursement for emergency services. However, when 99140 is reported for an unscheduled routine obstetric delivery with the one of the diagnosis codes listed below, 99140 will **not** be eligible for separate reimbursement.

ICD-9-CM Code	ICD-9-CM Description	ICD-10-CM Code	ICD-10-CM Description
650	Normal delivery	O80	Encounter for full-term uncomplicated delivery
654.20	Previous cesarean section, unspecified as to episode of care or not applicable	O34.21	Maternal care for scar from previous cesarean delivery
654.21	Previous cesarean section, delivered, with or without mention of antepartum condition	O34.21	Maternal care for scar from previous cesarean delivery

ICD-9-CM Code	ICD-9-CM Description	ICD-10-CM Code	ICD-10-CM Description
669.70	Cesarean delivery, without mention of indication, unspecified as to episode of care or not applicable	O82	Encounter for cesarean delivery without indication
669.71	Cesarean delivery, without mention of indication, delivered, with or without mention of antepartum condition	O82	Encounter for cesarean delivery without indication
V22.0	Supervision of normal first pregnancy	Z34.00	Encounter for supervision of normal first pregnancy, unspecified trimester
V22.0		Z34.01	Encounter for supervision of normal first pregnancy, first trimester
V22.0		Z34.02	Encounter for supervision of normal first pregnancy, second trimester
V22.0		Z34.03	Encounter for supervision of normal first pregnancy, third trimester
V22.1	Supervision of other normal pregnancy	Z34.80	Encounter for supervision of other normal pregnancy, unspecified trimester
V221		Z34.81	Encounter for supervision of other normal pregnancy, first trimester
V22.1		Z34.82	Encounter for supervision of other normal pregnancy, second trimester
V22.1		Z34.83	Encounter for supervision of other normal pregnancy, third trimester
V22.1		Z34.90	Encounter for supervision of normal pregnancy, unspecified, unspecified trimester

ICD-9-CM Code	ICD-9-CM Description	ICD-10-CM Code	ICD-10-CM Description
V22.1		Z34.91	Encounter for supervision of normal pregnancy, unspecified, first trimester
V22.1		Z34.92	Encounter for supervision of normal pregnancy, unspecified, second trimester
V22.1		Z34.93	Encounter for supervision of normal pregnancy, unspecified, third trimester
V23.81	Supervision of high-risk pregnancy of elderly primigravida	O09.511	Supervision of elderly primigravida, first trimester
V23.81		O09.512	Supervision of elderly primigravida, second trimester
V23.81		O09.513	Supervision of elderly primigravida, third trimester
V23.81		O09.519	Supervision of elderly primigravida, unspecified trimester
V23.82	Supervision of high-risk pregnancy of elderly multigravida	O09.521	Supervision of elderly multigravida, first trimester
V23.82		O09.522	Supervision of elderly multigravida, second trimester
V23.82		O09.523	Supervision of elderly multigravida, third trimester
V23.82		O09.529	Supervision of elderly multigravida, unspecified trimester
V23.83	Supervision of high-risk pregnancy of young primigravida	O09.611	Supervision of young primigravida, first trimester
V23.83		O09.612	Supervision of young primigravida, second trimester

ICD-9-CM Code	ICD-9-CM Description	ICD-10-CM Code	ICD-10-CM Description
V23.83		O09.613	Supervision of young primigravida, third trimester
V23.83		O09.619	Supervision of young primigravida, unspecified trimester
V23.84	Supervision of high-risk pregnancy of young primigravida	O09.621	Supervision of young multigravida, first trimester
V23.84		O09.622	Supervision of young multigravida, second trimester
V23.84		O09.623	Supervision of young multigravida, third trimester
V23.84		O09.629	Supervision of young multigravida, unspecified trimester
V23.85	Pregnancy resulting from assisted reproductive technology	O09.811	Supervision of pregnancy resulting from assisted reproductive technology, first trimester
V23.85		O09.812	Supervision of pregnancy resulting from assisted reproductive technology, second trimester
V23.85		O09.813	Supervision of pregnancy resulting from assisted reproductive technology, third trimester
V23.85		O09.819	Supervision of pregnancy resulting from assisted reproductive technology, unspecified trimester
V23.86	Pregnancy with history of in utero procedure during previous pregnancy	O09.821	Supervision of pregnancy with history of in utero procedure during previous pregnancy, first trimester

ICD-9-CM Code	ICD-9-CM Description	ICD-10-CM Code	ICD-10-CM Description
V23.86		O09.822	Supervision of pregnancy with history of in utero procedure during previous pregnancy, second trimester
V23.86		O09.823	Supervision of pregnancy with history of in utero procedure during previous pregnancy, third trimester
V23.86		O09.829	Supervision of pregnancy with history of in utero procedure during previous pregnancy, unspecified trimester
V23.89	Supervision of other high-risk pregnancy	O09.70	Supervision of high risk pregnancy due to social problems, unspecified trimester
V23.89		O09.71	Supervision of high risk pregnancy due to social problems, first trimester
V23.89		O09.72	Supervision of high risk pregnancy due to social problems, second trimester
V23.89		O09.73	Supervision of high risk pregnancy due to social problems, third trimester
V23.89		O09.891	Supervision of other high risk pregnancies, first trimester
V23.89		O09.892	Supervision of other high risk pregnancies, second trimester
V23.89		O09.893	Supervision of other high risk pregnancies, third trimester
V23.89		O09.899	Supervision of other high risk pregnancies, unspecified trimester

V. Services Included/Excluded in the Global Reimbursement for Anesthesia

Global reimbursement for the anesthesia service provided includes all procedures integral to the successful administration of anesthesia from the initial pre-anesthesia evaluation through the time when the anesthesiologist or other qualified health care professional in the same anesthesia provider group is no longer in personal attendance. (See also our Global Surgery reimbursement policy.)

Below are examples of services that the Health Plan considers included or excluded from global anesthesia reimbursement:

a. Examples of services and corresponding codes that the Health Plan considers to be included in global reimbursement for the anesthesia service and are not eligible for separate reimbursement:

- One day preoperative evaluation and management (E/M) services and 10 day post operative E/M services. The 10 day post operative period includes any E/M services that are a follow-up to the general anesthesia service, as well as any E/M services related to postoperative pain management for the surgical episode. The 10 day post operative period will apply to the anesthesiologist or other qualified health care professional who performed the general anesthesia, or to other providers in the same anesthesia provider group. Nerve block injections (for pain management) will be eligible for separate reimbursement.
- Placement of endotracheal and naso-gastric tubes (31500, 43753, 43754)
- Laryngoscopy and bronchoscopy procedures (31505, 31515, 31527, 31622, 31645)
- Placement and interpretation of any non-invasive monitoring, which may include ECG testing (93000-93010,93040-93042), monitoring of temperature/blood pressure/pulse oximetry (CPT 94760-94761), carbon dioxide, expired gas determination by infrared analyzer/capnography (CPT 94770) and mass spectrometry, and vital capacity (94150).
- Venipuncture and transfusion (36400-36440)
- Inhalation treatments (94640)
- Placement of peripheral intravenous lines and administration of fluids, anesthetic or other medications through a needle or tube inserted into a vein (36000, 96360-96361, 96365-96372)
- Echocardiography (93303, 93304, 93307, 93308)
- Electroencephalogram (EEG) (95812, 95813, and 95955)
- Daily hospital management of patient controlled analgesia (when a patient controls the amount of analgesia he or she receives)

b. The placement of catheters in arterial, central venous or pulmonary arteries (e.g., 36555-36556, 36620, 36625, 93503) are excluded from global reimbursement and are eligible for separate reimbursement

c. In accordance with National Correct Coding Initiative (NCCI) coding guidelines, the Health Plan requires that if a transesophageal echocardiography (TEE) is performed as a distinct and independent procedure from the anesthesia service provided, then modifier 59 must be appended to the TEE code in

the code range of 93312-93317 to be eligible for separate reimbursement. When TEE services are for monitoring purposes (CPT code 93318) or guidance of a transcatheter intracardiac or great vessel(s) structural intervention(s)… (CPT code 93355), the Health Plan follows NCCI edit logic for code pairs with a 'superscript' of zero or a modifier allowance indicator of zero, and will not override an incidental edit when modifier 59 is used.

d. When an anesthesiologist, a non-physician anesthesia provider, an anesthesia group, or any other professional provider in a facility setting, the medication charge will not be eligible for separate reimbursement even when reported with an unclassified or unspecified drug code (e.g., J3490). The Health Plan considers the provision of any medication, including Propofol, to be included under the facility's charge.

VI. Postoperative Pain Management

a. Postoperative pain management services by an anesthesiologist, such as an injection or catheter insertion into the epidural space or major nerve, are eligible for separate reimbursement. Postoperative pain management services are eligible for reimbursed at a maximum allowance and time units are not applicable. This applies to the following codes and ranges: 62310- 62319, 64412- 64425 and 64445 – 64450. When postoperative pain management services are performed bilaterally the unilateral code must be reported once with modifier 50 using the applicable base value for the unilateral code. The pain management code will be considered as one surgical service and will be eligible for reimbursement equal to 150% of the maximum allowance for the code.

b. An epidural or major nerve injection or catheter insertion performed by an anesthesiologist for postoperative pain management before, during, and/or following the surgical procedure is eligible for separate reimbursement in addition to the primary anesthesia code. Modifier 59 must be appended to the appropriate procedure code to indicate a distinct procedural service was performed.

c. The daily management of epidural drug administration (CPT 01996) for postoperative pain management performed by the anesthesiologist is eligible for reimbursement one time per date of service subsequent to the surgery date. However, when the daily management code is reported with an anesthetic injection code (such as CPT codes 62310, 62311, 62318 & 62319), only the injection code is eligible for reimbursement.

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[1]2013 Relative Value Guide®, ©2012 American Society of Anesthesiologists, pg. 24

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Use of Reimbursement Policy:
This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member's benefits on the date of service. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.