BlueCross BlueShield Minnesota

COMMERCIAL REIMBURSEMENT POLICY

Anesthesia

Active

Policy Number: Anesthesia Services – 001
Policy Title: Anesthesia
Section: Anesthesia Services
Effective Date: 12/01/23

Description

This policy addresses coding and reimbursement for anesthesia services.

Policy Statement

Anesthesia services may include but are not limited to general, regional, supplementation of local anesthesia, or other supportive services in order to afford the patient the anesthesia care deemed optimal by the anesthesiologist during a procedure.

Surgical services involving administration of anesthesia must be reported with procedure codes from the Anesthesia section of Current Procedural Terminology (CPT®) (00100-01999). Anesthesia codes, also known as "ASA" (American Society of Anesthesiology) codes, are to be reported by anesthesiologists and Certified Registered Nurse Anesthetists (CRNAs) only.

The Centers for Medicare and Medicaid Services (CMS) assigns a "base unit value" reflecting the work associated with the anesthetic management of a surgical procedure, to each ASA code. Blue Cross and Blue Shield of Minnesota (Blue Cross) utilizes the CMS base unit value, time units, modifiers and anesthesia conversion factor when calculating reimbursement for anesthesia services.

Base Unit Values

The base unit value takes into account the complexity, risk and skill required to perform the service. It includes all usual anesthesia services such as:

- The standard pre-operative and post-operative visits
- Administration of fluids and blood products incident to the anesthesia care
- Interpretation of non-invasive physiologic monitoring.

Services such as placement of arterial, central venous, and pulmonary artery catheters and use of transesophageal echocardiography (TEE) are not included in the base unit value.

Time Units

Anesthesia time is defined as the period during which an anesthesia provider is present with the patient. It starts when the anesthesia provider begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ends when the anesthesia provider is no longer furnishing anesthesia services to the patient (i.e. the patient is safely placed under postoperative care.) Anesthesia time can be counted in blocks of time if the anesthesia

provider is interrupted, but only if the time counted is that in which continuous anesthesia services are provided.

The anesthesia time is reported in one-minute increments in the units field of the 837P. Blue Cross will convert the total minutes reported into 15 minute increments when calculating reimbursement.

Time units are appropriate only for those procedures that are designated as “+ TM” in the ASA Relative Value Guide®.

Anesthesia Modifiers
Anesthesia modifiers are required to identify the provider (anesthesiologist or CRNA), and whether the service was personally performed, medically directed or medically supervised. Anesthesia modifiers are required when submitting ASA codes, and with the exception of the QS modifier, must be listed in the first modifier position. Anesthesia modifiers are to be used with ASA codes only. Other CPT codes submitted with anesthesia modifiers will be denied.

The following table indicates whether the anesthesia modifier is reimbursed at a full or part-time negotiated rate:

Modifier	Description	Reimbursement/Negotiated Rate
AA	Anesthesia services performed personally by anesthesiologist	Full-time
AD	Medical supervision by a physician: more than four concurrent anesthesia procedures	Part-time
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals	Part-time
QS	Monitored anesthesiology service See MAC services section for additional information.	Full-time
QX	Qualified nonphysician anesthetist service: With medical direction by a physician	Part-time
QY	Medical direction of one qualified nonphysician anesthetist by an anesthesiologist	Part-time
QZ	CRNA service: Without medical direction of a physician	Full-time

Medical Direction
When the physician is medically directing the CRNA in a single anesthesia case or is medically directing two, three or four concurrent procedures, the physician reports modifiers QY or QK. The CRNA reports modifier QX.

Medical Supervision
When the physician is involved in rendering more than four procedures concurrently or is performing other services while directing the concurrent procedures, modifier AD should be reported by the physician.

BlueCross BlueShield Minnesota

Monitored Anesthesia Care

Monitored anesthesia care (MAC) refers to instances in which an anesthesiologist has been called on to provide specific anesthesia services to a particular patient undergoing a planned procedure. In this case, the physician performs a preanesthetic examination, is physically present in the operating suite, monitors the patient's condition, makes medical judgments regarding the patient's anesthesia needs, and is prepared to furnish anesthesia service as necessary. MAC modifiers (G8, G9, QS) should be submitted in the second modifier position in addition to reporting the actual anesthesia time and one of the anesthesia payment modifiers in the first modifier position.

Modifier	Description
G8	Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure
G9	Monitored anesthesia care or patient who has history of severe cardiopulmonary condition
QS	Monitored anesthesiology care service

Monitored anesthesia care in an office place of service is eligible for reimbursement when reported with modifier QS.

Physical Status Modifiers

Physical status modifiers are used to describe the patient's health status and the associated complexity level of the anesthesia service provided. These modifiers are appropriate for use with ASA codes only and are reported in the second modifier position. Additional reimbursement may be made according to the base unit associated with the reported physical status modifier.

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

Qualifying Circumstances

Qualifying circumstances codes (99100, 99116, 99135, 99140) have been assigned a Status B indicator on the National Physician Fee Schedule (NPFS). Blue Cross therefore does not provide additional reimbursement for these codes. Refer to *Commercial General Coding – 071 Bundled Services Reimbursement Policy.*

Anesthesia Reporting for Multiple Surgery

Anesthesia services associated with multiple or bilateral surgical procedures performed during the same operative session should be reported with the single anesthesia code that has the highest base unit value. If multiple ASA codes are submitted for the same operative session, the lower valued ASA code(s) will be denied, with the exception of add-on anesthesia codes, which are listed separately in addition to the code for the primary procedure. The total anesthesia time for the combined total for all procedures should be reported.

Local Anesthesia

Local anesthesia is integral to the surgical procedure code and is not separately reimbursable.

Epidural or Peripheral Nerve Block Injection

- Epidural or peripheral nerve blocks administered by an anesthesiologist or CRNA as a component of the anesthesia service are not eligible for separate reimbursement as they are considered included in the anesthesia service and should be reported with an anesthesia code (0XXXX).
- An epidural or peripheral nerve block administered specifically at the request of the surgeon for postoperative pain management (62320-62327 or 64400-64530) may be reported separately on the same date of service as an anesthesia code if modifier 59 or XU is appended to indicate that it is separate from the surgical anesthesia. The injection may be administered preoperatively, intraoperatively, or postoperatively.

Separate documentation is required for epidural or peripheral nerve blocks done for post-operative pain management to distinguish it from the surgical procedure anesthesia.

Daily Management of Epidural or Subarachnoid Drug Administration

If an epidural or subarachnoid injection is used for intraoperative anesthesia and postoperative pain management, code 01996 (daily hospital management of epidural or subarachnoid continuous drug administration) is not separately reportable on the day of insertion of the epidural or subarachnoid catheter. Code 01996 may only be reported for management on days subsequent to the date of insertion of the epidural or subarachnoid catheter.
Removal of the epidural catheter alone does not constitute daily management. If the only service performed is removal of the catheter, code 01996 should not be reported.

Subsequent daily management of an epidural catheter performed in a setting other than a hospital should be reported using the appropriate Evaluation and Management code.

Epidural Anesthesia for Labor and Delivery

Epidural anesthesia for labor and delivery is reported with code 01967 and if applicable, add-on codes 01968 or 01969.

Patient Controlled Analgesia

Patient controlled analgesia for postoperative pain control is not separately reimbursable. However, it may be separately reimbursable for pain control without surgery, such as cancer.

Standby

Standby services (code 99360) are not separately reimbursable. Standby is considered incidental regardless of what is or is not billed with that service. This includes anesthesia standby which occurs when an anesthesiologist or CRNA is present in case his or her services

are required for anesthesia, but otherwise performs no medical intervention. Refer to *Evaluation and Management – 005 Standby Services Reimbursement Policy.*

Dental Anesthesia

Dental anesthesia provided by an oral maxillofacial dental provider must be reported using the appropriate dental anesthetic HCPCS code. ASA codes will be denied if submitted.

Documentation Submission

The anesthesia record (either at the facility or the provider's office) must clearly identify the professional(s) providing the anesthesia service and time must be documented when appropriate. Both the CRNA and anesthesiologist signatures must be present on the anesthesia record.

Anesthesia claims will be reviewed on post-payment audit and are subject to recovery if the policy guidelines are not followed.

Coverage

Eligible services will be subject to the subscriber benefits, applicable fee schedule amount and any coding edits.

The following applies to all claim submissions.

All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in the Provider Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be paid according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply subscriber coverage or provider reimbursement.

CPT/HCPCS Modifier:	AA	AD	G8	G9	P1	P2	P3
	P4	P5	P6	QK	QS	QX	QY
	QZ	XU	59	47			
ICD-10 Diagnosis:	N/A						
ICD-10 Procedure:	N/A						
CPT/HCPCS:	Refer to Appendix						
Revenue Codes:	N/A						

BlueCross BlueShield
Minnesota

Resources
American Society of Anesthesiologists Relative Value Guide®
Current Procedural Terminology (CPT®)
Healthcare Common Procedure Coding System (HCPCS)
Medicare Claims Processing Manual. Chapter 12 Sections 50,140
National Correct Coding Initiative (NCCI) Edits
National Government Services (NGS)

Policy History	
06/01/2015	Initial Committee Approval Date
10/12/2020	Annual Policy Review
01/26/2021	Code update: Removed 19366
12/28/2021	Annual Policy Review Code update: Added codes effective 1/1/2022 - 01937, 01938, 01939, 01940, 01941, 01942. Removed deleted codes for 1/1/2022 – 01935, 01936
01/01/2023	Code update: Removed code J2400
11/28/2023	Revised

2023 Current Procedural Terminology (CPT®) is copyright 2022 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use.

Copyright 2023 Blue Cross Blue Shield of Minnesota

BlueCross BlueShield Minnesota

Appendix

00100	00102	00103	00104	00120	00124	00126	00140	00142	00144
00145	00147	00148	00160	00162	00164	00170	00172	00174	00176
00190	00192	00210	00211	00212	00214	00215	00216	00218	00220
00222	00300	00320	00322	00326	00350	00352	00400	00402	00404
00406	00410	00450	00454	00470	00472	00474	00500	00520	00522
00524	00528	00529	00530	00532	00534	00537	00539	00540	00541
00542	00546	00548	00550	00560	00561	00562	00563	00566	00567
00580	00600	00604	00620	00625	00626	00630	00632	00635	00640
00670	00700	00702	00730	00731	00732	00750	00752	00754	00756
00770	00790	00792	00794	00796	00797	00800	00802	00811	00812
00813	00820	00830	00832	00834	00836	00840	00842	00844	00846
00848	00851	00860	00862	00864	00865	00866	00868	00870	00872
00873	00880	00882	00902	00904	00906	00908	00910	00912	00914
00916	00918	00920	00921	00922	00924	00926	00928	00930	00932
00934	00936	00938	00940	00942	00944	00948	00950	00952	01112
01120	01130	01140	01150	01160	01170	01173	01200	01202	01210
01212	01214	01215	01220	01230	01232	01234	01250	01260	01270
01272	01274	01320	01340	01360	01380	01382	01390	01392	01400
01402	01404	01420	01430	01432	01440	01442	01444	01462	01464
01470	01472	01474	01480	01482	01484	01486	01490	01500	01502
01520	01522	01610	01620	01622	01630	01634	01636	01638	01650
01652	01654	01656	01670	01680	01710	01712	01714	01716	01730
01732	01740	01742	01744	01756	01758	01760	01770	01772	01780
01782	01810	01820	01829	01830	01832	01840	01842	01844	01850
01852	01860	01916	01920	01922	01924	01925	01926	01930	01931
01932	01933	01937	01938	01939	01940	01941	01942	01951	01952
01953	01958	01960	01961	01962	01963	01965	01966	01967	01968
01969	01990	01991	01992	01996	01999				
62320	62321	62322	62323	62324	62325	62326	62327	64400	64405
64408	64415	64416	64417	64418	64420	64421	64425	64430	64435
64445	64446	64447	64448	64449	64450	64451	64454	64455	64461
64462	64463	64479	64480	64483	64484	64486	64487	64488	64489
64490	64491	64492	64493	64494	64495	64505	64510	64517	64520
64530									
92960	99360								
99100	99116	99135	99140						
D9223									
J0670	J2001	S0020							