# ANESTHESIA, PROFESSIONAL AND FACILITY

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## Description

Anesthesia services include all services typically associated with the administration and monitoring of analgesia or anesthesia in order to produce partial or complete loss of sensation and/or consciousness. For purposes of this reimbursement policy, anesthesia services include general anesthesia, regional anesthesia, and monitored anesthesia care (MAC).

Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) codes and modifiers provide necessary detail to services rendered. Blue Cross NC follows the instruction and guidance of code and claim form issuers, including but not limited to CPT®, HCPCS, UB-04, and ICD-10.

In accordance with the North Carolina Medical Board Position Statement entitled Office Based Procedures, *"Anesthesia should be administered by an anesthesiologist or a CRNA supervised by a physician. The physician who performs the surgical or special procedure should not administer the anesthesia. The anesthesia provider should not be otherwise involved in the surgical or special procedure."*

Blue Cross Blue Shield North Carolina (Blue Cross NC) uses several factors in determining reimbursement for anesthesia care, including but not limited to: base units, time units, conversion factors, and modifiers. Claims may be processed according to same provider or same group practice. Same group practice is defined as a physician and/or other qualified health care professional of the same group and same specialty with the same Federal Tax ID number.

## Policy

**Blue Cross NC will reimburse anesthesia services according to the criteria outlined in this policy.**

## Reimbursement Guidelines

The administration of local anesthesia or for anesthesia administered by the operating surgeon or surgical assistant is considered incidental to the surgical procedure. This includes sedation given for endoscopic procedures including colonoscopy. Separate reimbursement is not provided for incidental services. All anesthesia services are subject to Blue Cross NC bundling guidelines.

**Anesthesia Time**
Anesthesia time must be reported in one (1) minute increments. Anesthesia time should begin when the Medical Doctor of Anesthesia (MDA) or Certified Registered Nurse Anesthetist (CRNA) begins personal and continuous preparation of the patient for induction of anesthesia in the operating room or an equivalent area (i.e., holding area). It is recognized that services rendered in the holding area will result in variance of operating room time when compared to actual time of anesthesia administration. Anesthesia time ends when the patient's condition can safely be managed by post-operative supervision other than the personal attention of the MDA or CRNA.

Anesthesia time units are calculated at one (1) unit for each minute of anesthesia time. Anesthesia base units and the anesthesia provider's Conversion Factor (CF) are adjusted by Blue Cross NC (internally) relative to this one (1) minute time unit, i.e., the base unit value is multiplied by fifteen (15) and the CF is divided by fifteen (15). Blue Cross NC considers the following list of codes to be non-timed procedures, which may differ from the ASA relative value guide:

| CPT Code | Description |
|---|---|
| 01960 | Anesthesia for vaginal delivery |
| 01967 | Neuraxial labor analgesia/anesthesia for planned vaginal delivery |
| 01996 | Daily hospital management of epidural or subarachnoid continuous drug administration |

CFs are based on fifteen (15) minute increments. For example, in a procedure with an anesthesia base unit value of four (4) requiring two (2) hours and twelve (12) minutes of anesthesia time (properly reported as one hundred and thirty-two [132] in the claim's units field): the time units (one hundred and thirty-two [132]) are added to the base unit value of sixty (60), (or four [4] x fifteen [15]), producing a total unit value of one hundred and ninety-two (192) units for this anesthesia service.

This total unit value is then multiplied by the provider's CF (CF divided by fifteen (15) and rounded to the nearest cent).

**Example 1: Method for calculating reimbursement for timed anesthesia procedures**

| **Scenario:** | **Allowance:** |
|---|---|
| CT= $30.00<br>Base unit = 4<br>Time units = 2 hrs, 12 mins (or 132 mins) | = ($CF/15) x ([base unit x 15] + min)<br>= ($30.00/15) x (4[ x 15] + 132)<br>= $2.00 x (60 + 132)<br>= $2.00 x 192<br>= **$384.00** |

**Anesthesia Modifiers**

All anesthesia services are reported by use of the anesthesia five (5) digit procedure code plus the addition of a modifier(s). Modifiers are added to modify or give additional definition to the service performed, and in certain circumstances add additional units to the base unit values. The anesthesia modifier must be submitted in the first position after the procedure code, before other non-anesthesia modifiers. Physical status modifiers must be listed before other modifiers on the anesthesia claim. Please include all modifiers for a procedure code on one (1) line. All anesthesia services reported should include three details: anesthesia CPT® code, anesthesia modifier, and physical status modifier. Surgical codes are not to be reported with anesthesia modifiers. Every timed service must have a modifier.

| Anesthesia Modifiers | |
|---|---|
| AA | Anesthesia services performed personally by anesthesiologist |

| | |
|---|---|
| AD | Medical supervision by a physician: more than 4 concurrent anesthesia procedures |
| AD | Direction of residents in furnishing not more than 2 concurrent anesthesia procedures |
| QK | Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals |
| QS | Monitored anesthesiology care services (can be billed by a qualified nonphysician anesthetist or a physician) |
| QX | Qualified nonphysician anesthetist with medical direction by a physician |
| QY | Medical direction of one qualified nonphysician anesthetist by an anesthesiologist |
| QZ | CRNA service: without medical direction by a physician |

**Physical Status Modifiers**

When filed with a five (5) digit procedure code, the following modifiers will add additional unit(s) to the base unit value.

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

The above six (6) levels are consistent with the ASA's ranking of patient physical status. Physical status is included in CPT-4 to distinguish between various levels of complexity of the anesthesia service provided.

**Multiple General Anesthesia Services**

When multiple general anesthesia services are performed on the same date of service, only the procedure with the highest base value should be reported, in addition to the time for all anesthesia services combined. Since only one anesthesia code should be reported per date of service, any additional anesthesia codes will not be

eligible for reimbursement when a different code from the same range has been previously paid for the same date of service.

**Daily Hospital Management**

Daily hospital management of epidural or subarachnoid continuous drug administration should not be reported with anesthesia qualifying circumstance codes or physical status modifiers. Anesthesia qualifying circumstance codes should always be reported with the appropriate primary anesthesia procedure codes.

**Monitored Anesthesia**

Certain anesthesia services appended with the QS modifier will not be eligible for reimbursement without an appropriate diagnosis or a physical status modifier of P3, P4, or P5, or MAC modifiers G8 or G9 on the claim.

**Anesthesia for Pain Management Injections**

Under most routine circumstances, minor pain management procedures, including but not limited to, epidural steroid injections, trigger point injections, and epidural blood patch, only require local anesthesia. For adults, an accompanying surgical procedure (other than a pain management procedure) must also be present on the claim for the associated anesthesia and moderate sedation service to be eligible for reimbursement.

**Dental Anesthesia**

Anesthesia provided by a dental provider must be reported using the appropriate dental anesthetic HCPCS code. ASA codes will not be eligible for reimbursement if submitted.

**Anesthesia Supplies**

Regardless of place of service, Blue Cross NC considers anesthesia supplies incidental to the anesthesia service codes (00100 - 01999) and will not be eligible for separate reimbursement.

## Rationale

Anesthesia services as defined in this policy will be reimbursed consistent with guidance from CMS, expert medical society standards as set forth herein and in accordance with correct coding guidelines.

## Billing and Coding

Applicable codes are for reference only and are **not** all inclusive. For further information on reimbursement guidelines, please see the Blue Cross NC web site at Blue Cross NC.

## Related policy

**Anesthesia Services (Medical Policy)**

**Bundling Guidelines**

**Guidelines for Global Maternity Reimbursement**

**Modifier Guidelines**

**Pricing & Adjudication Principles**

**Spinal Manipulation under Anesthesia (Medical Policy)**

## References

American Society of Anesthesiologists (ASA) and ASA Relative Value Guide

Healthcare Common Procedure Coding System

American Medical Association, *Current Procedural Terminology* (CPT®)

Centers for Medicare & Medicaid Services, CMS Manual System, Medicare Claims Processing Manual 100-04, OPPS, and OCE

## History

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|---|---|
| 6/1/2022 | New policy developed. Medical Director approved. **Notification on 3/31/2022 for effective date 6/1/2022**. (eel) |
| 8/1/2022 | "Anesthesia Supplies" added to Reimbursement Guidelines section. **Notification on 6/1/2022 for effective date 8/1/2022**. (ckb) |
| 12/31/2022 | Routine Policy Review. Minor revisions only. (cjw) |

## Application

These reimbursement requirements apply to all commercial, Administrative Services Only (ASO), and Blue Card Inter-Plan Program Host members (other Plans members who seek care from the NC service area). This policy does not apply to Blue Cross NC members who seek care in other states.

This policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore, member benefit language should be reviewed before applying the terms of this policy.

## Legal

Reimbursement policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and Blue Cross NC reserves the right to review and revise its medical and reimbursement policies periodically.