Anesthesia Reimbursement Guidelines

Reimbursement Policy:

Anesthesia Reimbursement Guidelines

Effective Date:

November 1, 2007

Last Reviewed Date:

January 26, 2023

Purpose:

Provide guidelines for the reimbursement of anesthesia services.

Scope:

All products are included, except:

- Products where Horizon BCBSNJ is secondary to Medicare (i.e., Medigap).
- COB.

All Insured and Administrative Services Only (ASO) accounts are included.

Definitions:

Anesthesia - the administration of a drug or anesthetic agent by an anesthesiologist in order for a patient to obtain muscular relaxation and partial or total loss of sensation and/or consciousness.

Anesthesia time - the actual number of anesthesia minutes as reported on the claim. Anesthesia time begins when the anesthetist begins to prepare the patient for the induction of anesthesia in the operating room or in an equivalent area and ends when the anesthetist is no longer in personal attendance, that is, when the patient may be safely placed under post-anesthetic supervision.

Base unit value - each anesthesia code (procedure codes 00100-01999) is assigned a base unit value by the American Society of Anesthesiologists (ASA) and used for the purpose of establishing fee schedule allowances. Anesthesia services are paid on the basis of a relative value system, which include both base and actual time units. Base units take into account the complexity, risk, and skill required to perform the service.

Base Unit - value for each anesthesia code that reflects all activities other than anesthesia time. Anesthesia activities include usual pre-operative and post-operative visits, the administration of fluids or blood incident to anesthesia care, and monitoring services.

Policy:

This policy has been developed using guidelines from the American Society of Anesthesiologists (ASA), the American Medical Association (AMA), and the Centers for Medicare and Medicaid Services (CMS). Anesthesia services must be reported using the appropriate procedure code from the anesthesia section of the Current Procedural Terminology (CPT®) book (00100-01999).

Horizon BCBSNJ's reimbursement for anesthesia and anesthesia-related services shall be valued according to the ASA's Relative Value Guide (RVG), the ASA Crosswalk and/or St. Anthony's Relative Values for Physicians.

Horizon BCBSNJ shall only reimburse the first eligible submission of an anesthesia code when multiple anesthesia services are reported by the same physician (or physician group), different physician or other qualified health care professional for the same patient on the same date of service. Reimbursement percentages are based on appropriate anesthesia modifier(s) being reported.

The CPT codes and nomenclature used in this Policy are subject to revision and/or change by the American Medical Association. In the event of such changes, the Policy will continue to be in force, albeit applied to the new or amended coding so issued until such time as the Policy is reviewed and updated to reflect the new or amended coding.

Procedure:

Time Reporting

Consistent with CMS guidelines, Horizon BCBSNJ shall require time-based anesthesia services be reported with actual Anesthesia Time in one-minute increments. For example, if the Anesthesia Time is one hour, then 60 minutes should be submitted.

Every 15-minute interval will be converted by Horizon BCBSNJ into 1 unit, rounding up to the next unit for 8 to 14 minutes, rounding down for 1 to 7 minutes.

- If the remainder of minutes is 7.99 or less, round the unit down.
- If the remainder of minutes is 8.00 or more, round the unit up.

Reimbursement Formula

Time-based anesthesia services are reimbursed according to the following formula:
(Time Units + Base Units) x Conversion Factor = Allowance

Anesthesia Modifiers

All anesthesia services shall be reported by use of anesthesia 5 digit procedure code plus applicable modifiers. Reimbursement guidelines for the anesthesia modifiers are noted below and would be applied to the Horizon BCBSNJ anesthesia allowance:

Modifier	Description	Reimbursement
AA	Anesthesia Services performed personally by the anesthesiologist.	Services are paid at 100% of the applicable Horizon allowance.*
AD	Medical supervision by a physician, more than 4 concurrent anesthesia procedures.	Services are paid at 50% of the applicable Horizon allowance.*
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals.	Services are paid at 50% of the applicable Horizon allowance.*
QY	Medical direction of one CRNA by an anesthesiologist.	Services are paid at 50% of the applicable Horizon BCBSNJ allowance.*
QX	CRNA service, with medical direction by a physician.	Services are paid at 50% of the applicable Horizon allowance*.
QZ**	CRNA service, without medical direction by a physician.	Services are not eligible and should be denied.

The reimbursement rate for the overall anesthesia services performed during a procedure will not exceed 100% of Horizon BCBSNJ's allowance.

"*Horizon BCBSNJ allowance is determined by the provider's network status, group benefit design, place of service where services are rendered or a combination thereof."

**ITS home claims, Medicare Secondary, Federal Employee Health Program and claims submitted for the Horizon Medicare Advantage (MRSK) members when billed with a Modifier QZ are paid at 100% of the applicable Horizon allowance* which is based upon New Jersey's Administrative Code.

Note: The Anesthesia Modifiers listed above are pricing modifiers and must be listed in the first position to insure correct reimbursement. If the above modifiers are billed together, reimbursement will be at the lesser reimbursement percentage

Modifiers QS, G8 and G9 are **informational only**, and do not affect reimbursement. Informational modifiers must be used in the second modifier position when billed in conjunction with a pricing anesthesia modifier (which must be submitted in the first modifier position). Claims submitted with the informational modifier(s) without a valid anesthesia pricing modifier will be denied.

QS	Monitored anesthesia care service (MAC).
G8	MAC for deep complex complicated or markedly invasive surgical procedures and may be used in lieu of modifier QS.
G9	MAC for a patient who has a history of severe cardiopulmonary condition and may be used in lieu of modifier QS.

Duplicate Anesthesia Services

Duplicate anesthesia services submitted by the same physician (or physician group), different physician or other qualified health care professional for the same patient on the same date of service will be denied.

LIMITATIONS AND EXCLUSIONS:

While reimbursement is considered, payment determination is subject to, but not limited to:

- Group or individual benefit
- Provider participation agreement
- Routine claim editing logic, including but not limited to incidental or mutually exclusive logic, and medical necessity
- Mandated or legislative required criteria will always supersede.

History:

2007: Policy Approved
07/22/2015: Combined anesthesia policies #002, 012 and 013 into this single policy.
05/25/2106: Added information to Policy and Procedure section about processing of duplicate anesthesia services.

Policy 012_v3.0_01262023