Commercial Reimbursement Policy

Subject: **Anesthesia Services – Professional**	
Policy Number: **C-09002**	Policy Section: **Anesthesia**
Last Approval Date: **06/12/2024**	Effective Date: **11/01/2024**

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by an Anthem member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

Anthem allows reimbursement for anesthesia services rendered by professional providers based upon:

- American Society of Anesthesiologists (ASA) anesthesia formula unless otherwise noted in the exemption section.
- Proper use of applicable modifiers.
- Additional factors such as field avoidance and unusual positioning.

Services involving the administration of anesthesia are reported by using anesthesia codes and, if applicable, a physical status modifier and/or a servicing modifier.

I. Time

Providers must report anesthesia services in one-minute increments and note in the units field. For the first four (4) hours: one (1) unit equals five (5) to fifteen (15) minutes. Anesthesia claims submitted with an indicator other than minutes may be rejected or denied. After the first four (4) hours, one (1) unit equals five (5) to ten (10) minutes. Any time increments less than five (5) minutes will be ignored in reimbursement calculations. Start and stop times must be documented in the member's medical record. Anesthesia time starts with the preparation of the member for administration of anesthesia and stops when the anesthesia provider is no longer in personal attendance. 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.

II. Anesthesia Modifiers

Anesthesia modifiers are appended to the applicable procedure code to indicate the specific anesthesia service or to indicate who performed the service. Modifiers identifying who performed the anesthesia must be billed in the primary modifier field to receive appropriate reimbursement. Claims submitted for anesthesiology services without the appropriate modifier will be denied. The total reimbursement for anesthesia services provided by a physician/anesthesiologist and a non-physician anesthesia provider will not exceed 100% of the eligible amount that would be allowed had the anesthesia service been provided by only the physician/anesthesiologist. Please note specific anesthesia modifiers located in the related coding section below.

Physical Status Modifiers

Anthem does not recognize unit values for physical status modifiers and no additional reimbursement is allowed.

III. Multiple Procedures

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 Anthem 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.

IV. Field Avoidance and Unusual Positioning

Anthem allows any procedure around the head, neck, or shoulder girdle, requiring field avoidance, or any procedure requiring a position other than supine or

lithotomy, to have a minimum base value of 5 regardless of any lesser base value assigned to such procedure.

Unusual positioning is not eligible for additional reimbursement even when reported with modifier 22.

V. Qualifying Circumstances for Anesthesia

Anthem considers qualifying circumstances to be always bundled when reported in addition to the anesthesia procedure or service provided.

The following CPT codes identify qualifying circumstances:

- 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.

VI. Anesthesia for Oral Surgery

Anthem allows reimbursement for anesthesia for covered oral surgical procedures reported with appropriate CDT based anesthesia codes (D9211 - D9248).
We do not allow reimbursement for anesthesia rendered during oral surgery when the same claim is reported with both CPT and CDT codes as follows:

- CPT anesthesia codes 00170 - 00176 which describes anesthesia for intraoral procedures will not be eligible for reimbursement when reported with a CDT procedures.
- CDT anesthesia codes D9211 - D9248 will not be eligible for separate reimbursement when reported with CPT procedure codes.

Anthem requires an oral surgeon reporting services with a CPT procedure and also provides an anesthesia service to append modifier 47. In this instance, there is no additional reimbursement for the anesthesia. Only the oral surgery procedure is eligible for reimbursement.

VII. 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. In accordance with NCCI coding guidelines, Anthem considers the following services included in global reimbursement for anesthesia services and are not eligible for separate reimbursement:

- Daily hospital management of patient-controlled analgesia (when a patient controls the amount of analgesia he or she receives).
- Echocardiography.
- Electroencephalogram.
- Inhalation treatments.
- Laryngoscopy and bronchoscopy procedures.
- Placement and interpretation of any non-invasive monitoring, which may include ECG testing monitoring of temperature/blood pressure/pulse oximetry carbon dioxide, expired gas determination by infrared analyzer/capnography) and mass spectrometry, and vital capacity.

- Placement of endotracheal and naso-gastric tubes.
- Placement of peripheral intravenous lines and administration of fluids, anesthetic or other medications through a needle or tube inserted into a vein.
- Venipuncture and transfusion.

Anthem considers one-day preoperative evaluation and management (E/M) services and 10-day postoperative E/M services; the 10-day postoperative 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 postoperative 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.

When an anesthesiologist, a non-physician anesthesia provider, an anesthesia group, or any other professional provider, separately reports a medication in a facility setting, the medication will not be eligible for separate reimbursement even when reported with an unclassified or unspecified drug code. Anthem considers the provision of any medication, including Propofol, to be included under the facility's charge.

Anthem allows separate reimbursement for the following services provided in conjunction with anesthesia procedures:

- Swan-Ganz catheter insertion.
- Central venous pressure line insertion.
- Intra-arterial lines.
- Transesophageal echocardiography (TEE):
    - In accordance with National Correct Coding Initiative (NCCI) coding guidelines, Anthem requires that if a transesophageal echocardiography (TEE) is performed as a distinct and independent procedure from the anesthesia service provided, then the appropriate modifier must be appended to the TEE code in the code range of 93312-93317 to be eligible for separate reimbursement.
    - If TEE services are for monitoring purposes (e.g., CPT code 93318) or guidance of a transcatheter intracardiac or great vessel(s) structural intervention(s) (e.g., CPT code 93355), Anthem will follow NCCI edit logic and consider the codes incidental and a bypass modifier will not override.

VIII. Postoperative Pain Management

- 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 reimbursement and time units are not applicable. This applies to the following codes and ranges: 62320-62327, 64400-64450.
- 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 allowance for the code.
- 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. The appropriate modifier must be appended to the appropriate procedure code to indicate a distinct procedural service was performed.

- The daily hospital management of epidural or subarachnoid continuous drug administration (CPT code 01996) for postoperative pain management performed by the anesthesiologist is eligible for reimbursement once per date of service following the surgery date. However, when the daily management code is reported with an anesthetic injection code such as CPT codes 62320-62327, only the injection code is eligible for reimbursement. Modifiers will not override the edits.
- Anthem will deny daily hospital management of epidural or subarachnoid continuous drug administration procedure code when billed with a physical status modifier or qualifying circumstance procedure codes.

Related Coding

Description	Coding Grids
Anesthesia Modifiers	Anesthesia Modifiers

Policy History

06/12/2024	Review approved 06/12/2024 and effective 11/01/2024: • updated policy title from Professional Anesthesia Services • updated language for qualifying circumstances to always bundle • added modifiers G8, G9 and QS to the Related Coding section • updated modifier QZ reimbursement from 100% • added Physical Status Modifiers language
11/25/2020	Review approved: updated definition section; minor administrative changes; addition of modifier grid and diagnosis code list as attachments
06/01/2019	Review approved: updated policy template; added definitions
11/16/2018	Review approved: updated policy language in all sections; created market exemption table; retained modifier table and ICD-10 table
02/07/2017	Review approved: • deleted duplicate entries of routine maternity diagnoses O34.21 and O82 and put codes in sequential order. • removed deleted codes and added 2017 codes for spinal injections (62320-62327) under “Pain Management” section; no change to editing concept.
09/06/2016	Review approved: • updated language such has clarifying that services reported by both MD and midlevel will not allow more than 100% of allowable amount. • removed ICD-9 codes. • Included descriptions of CPT codes and modifiers where none existed. • removed 64412 under post-op pain management section; code deleted in 2016.
01/05/2016	Review approved: added back language that modifiers G8, G9, and QS

	are informational and are to be reported in a subsequent modifier field when reported with a servicing modifier; this language is bracketed; we are also retaining the language added at the CPRC meeting of 12/10/2015 and bracketing this language as well, this way either language content may be used at the local level if needed
12/01/2015	Review approved: Included modifiers G8, G9, QS (Monitored anesthesia care) in the modifiers table stating that the use of these modifiers with general anesthesia codes will cause the anesthesia service to deny; the modifiers are informational only and do not apply any pay percent's; removing the line under the modifier table that states these modifiers may be reported in a subsequent modifier field
05/05/2015	Review approved: Pg. 10: • Updated bullet 6.c. to include the new 2015 transesophageal echocardiography (TEE) code 93355 as not allowed with an anesthesia service, that we follow NCCI logic for this code the same as we do for TEE code 93318— superscript of "0" not allowed with the primary service (anesthesia) and modifier will not override. • Updated grammar also on the same page, bullet 6.d., for professional provider separately reporting charges for medication in a facility setting, the medication is not eligible for reimbursement. • updated the diagnosis table to be cleaner (as was done in the Routine OB policy presented last month).
11/04/2014	Review approved: • updated name of policy to add "Services" to the title (Anesthesia Services). • updated language under the Servicing Modifiers section on pg. 2; does not change any criteria or edits. • added information On Pg. 3 that Modifiers AA, AD, QK, QX, QY, or QZ are required to be listed in the first modifier field of the claim; these are pay percent modifiers for anesthesia and by having these modifiers in the first modifier field ensures the correct pay percent for services identified with these modifiers are applied. • updated language under section V for "Anesthesia for Oral Surgery" to paragraph 2 on pg. 9; again, no criteria or edit changes. • Updated language under section 6 d on pg. 10, that states we do not reimburse medication reported by a professional provider in a facility place of service; no criteria or edit changes. • updated language under section 7 on pg. 10 for Pain Management, to include the phrase "postoperative" since this section truly does address postoperative pain management services; no criteria or edit changes are associated with this update.

04/01/2014	Review approved: updated the routine OB diagnosis code table to include ICD-10 codes along with minor non-substantive updates to punctuation, grammar throughout the policy
06/04/2013	Review approved: Pg. 5: • A decision was made to remove the section on obstetrical anesthesia. Obstetrical anesthesia is more of a contracting issue at this point in time and locals may include language for OB anesthesia services if they choose to do so. Pg. 6: • The first bullet under 6a—examples of services included in the global reimbursement: the language has been updated regarding the preop and postop days will apply to postop nerve block injections for pain management; removed reference to ClaimsXten since the first bullet under section a is not ClaimsXten but rather a policy change. • Below are examples of services Empire considers included or excluded from global anesthesia reimbursement: o Examples of services and corresponding codes that Empire considers to be <u>included</u> in global reimbursement for the anesthesia service and are <u>not</u> eligible for separate reimbursement: o One day preoperative evaluation and management (E/M) services and 10 day post operative E/M services. The 10-day postoperative 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 post operative pain management for the surgical episode. The 10 day post operative period will apply to the anesthesiologist or other qualified healthcare 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. • 9th bullet under 6a)—reversed the spelling out of Electroencephalogram and abbreviation of EEG. • Other minor punctuation corrections.
03/05/2013	Review approved: • Pg. 4, section 3 on field avoidance will not allow additional reimbursement; base units will be at published units even if less than 5; bracket the two different paragraphs due to contracting and adoption. • updated coding on pg. 6, section 7a, second bullet: Placement of endotracheal and naso-gastric tubes (31500, 437543, 437534). • Pg. 7, section 7c: Spell out National Correct Coding Initiative (NCCI). • updated language on pg. 7, section 7d: Empire considers the provision of any medication, including Propofol, to be included

	under the facility's charge. Therefore, if a medication is separately reported by an anesthesia provider in a facility setting, the drug charge will not be eligible for separate reimbursement even when reported with an unclassified or unspecified drug code (e.g., J3490).
09/11/2012	Review approved: • The paragraph referencing section 6 on pg. 1 has been removed and the language for section 6 (oral anesthesia) has now been bracketed. • bracketed language on pg. 1, 4th and 5th bullets; not all plans requesting the reporting of minutes. • expanded language for modifier AS in the coding table on pg. 3 ○ Update coding on pg. 6, section 7 for endo and naso-gastric tubes (updated codes 43200, 43754. 43753 to replace deleted codes 91000, 91055, 91105; and add 94150 for vital capacity • Expanded description of capnography on pg. 6 • Added bullet for section 7, pg. 7 regarding the provision of medication in a facility setting will not be eligible for separate reimbursement • 10/05/12: Section 8 a. pg. 7, Pain Management —added brackets to [using the applicable base value for the unilateral code] under this section as most state use a single fee rather than base units for the pain management codes when performed bilaterally.
11/15/2011	Review approved: corrected footnote #s
09/13/2011	Review approved: • #5 the 1st statement under obstetric anesthesia was clarified to read "using a single fee method…of accounting for time." Rather than "A time accounting method…" • #7 a reference to the Global Surgery policy was added • Under a. "for the anesthesia service" was added for clarification • The 1st bullet under a. was condensed since the 10 global was implemented last year
08/10/2011	Review approved: the wording in the 1st sentence of the OB section (#5) was revised to further clarify that we are using the single fee method listed in the ASA RVG[4] of accounting for time. The prior statement indicated that but was not stated as clearly.
06/21/2011	Review approved: updated footnote reference from RV Guide from 2009 to 2010
06/07/2011	Review approved: • middle of 3rd page, Section 2.a. Servicing Modifiers, a 5th bullet was added to indicate that the 50% reduction for mod QK, QX, and QY also applies to 60000 series codes. • page 5 ICD-9 coding table has three new diags added V23.85-V23.89 to match the recent decision for the OB policy regarding "normal pregnancy"
03/08/2011	Review approved: accepted formatting changes to eliminate mark-ups but no wording changes made

10/05/2010	Review approved: • after EPR approval this policy went for legal review. Some very minor wording grammatical wording tweaks were made: Insert date was used rather than XXXX; "unit's" was changed to "units" in Phys Stats section; and "are eligible for "reimbursement" was added to 2nd time bullet. • Section 6 of this policy was marked as not signed off on as a policy statement due to legal concerns regarding fee schedule and messaging to members. These issues will be worked prior to implementation.
08/03/2010	Review approved: changed code range in Section 7c. to 93317 and an asterisked sentences was added that 93318 is a 0 superscript code and 59 will not override edit
07/06/2010	Review approved: • in the description section, base units are derived from Medicare was changed to derived from the ASA RVG • in the policy section, in the 2nd bullet on time, and exception was added in parentheses that add on codes 01953, 01968-01969 are separately reimbursed. • in section 2.b under Physical Status modifiers, a bracketed statement was added indicating that our system is not automated, and providers need to add the appropriate units when appending P3-P5 codes. • under policy section #4 instead of "we follow", "Empire was referenced and ClmsXtn or claim editing system was bracketed. • Section #6 on oral surgery was re-written to clarify our policy position. • in Section 7a. first bullet point: effective date for 10 day global was added and in the 4th bullet codes 93015-93018 was removed since these codes do not deny with anesthesia procedures. • in Section 7b. TEE codes were removed • Section 7c. was added to indicate that TEE codes 93312-93318 are included in NCCI edits and mod 59 must be appended for separate reimbursement.
12/14/2009	Review approved: updated do not report 01996 with a physical status modifier or qualifying circumstances code; added 3rd paragraph was to section #2.b.; added an asterisk note was to section #4.2nd paragraph; added footnote #3 for sourcing
09/14/2009	Review approved: updated heading and policy history section with new format
04/17/2009	Review approved: minor language changes
02/03/2009	Initial approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- CMS

- Optum EncoderPro 2023

Definitions

Anesthesia	Refers to the drugs or substances that cause a loss of consciousness or sensitivity to pain
Base Units (BU)	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)
Conversion Factor (CF)	A geographic-specific amount that varies by the locality where the anesthesia is administered
General	Drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation.
Local	Loss of sensation in a limited and superficial area of the body
Regional	Delivery of anesthetic medication at a specific level of the spinal cord and/or to peripheral nerves is used when loss of consciousness is not desired but sufficient analgesia and loss of voluntary and involuntary movement is required
Time Units (TU)	An increment of fifteen (15) minutes where each 15-minute increment constitutes one (1) time unit
General Reimbursement Policy Definitions	

Related Policies and Materials

Global Surgical Package - Professional
Modifier Usage - Professional
Scope of License - Professional

Use of Reimbursement Policy
State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, take precedence over Reimbursement Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.