Commercial Reimbursement Policy

Subject: **Professional Anesthesia Services**	
Policy Number: **C-09002**	Policy Section: **Anesthesia**
Last Approval Date: **11/25/2020**	Effective Date: **11/25/2020**

Disclaimer

These 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 a member's Anthem Blue Cross (Anthem) 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. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Our policies apply to both participating and non-participating professionals and facilities as indicated.

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These policies may be superseded by provider or state contract language, or state, federal requirements or mandates. 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. Anthem reserves the right to review and revise these policies periodically when necessary. When there is an update, we will publish the most current policy to the website.

Policy

The Health Plan 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 qualifying circumstances, 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. To calculate reimbursement for time, the number of minutes reported is divided by 15 (minutes) and rounded to the nearest tenth to provide a unit of measure. Anesthesia claims submitted with an indicator other than minutes may be rejected or denied. 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. Modifiers G8, G9, or QS may be reported in a subsequent modifier field when the service rendered is monitored anesthesia care (MAC). 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 (e.g., certified registered nurse anesthetist (CRNA), anesthesia assistant (AA), etc.) 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

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. Please note specific anesthesia modifiers located in the related coding section below.

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 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.

IV. Field Avoidance and Unusual Positioning

The Health Plan 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

The Health Plan allows reimbursement for qualifying circumstances when reported, in addition to the anesthesia procedure or service provided. The following CPT codes are reported in addition to the anesthesia procedure or service provided to identify qualifying circumstances:

- 99100 Anesthesia for patient of extreme age, younger than 1 year and older than 70
  **See CPT parenthetical statement under anesthesia codes 00326, 00561, 00834, and 00836 for infants younger than 1 year of age
- 99116 Anesthesia complicated by utilization of the total body hypothermia
- 99135 Anesthesia complicated by utilization of controlled hypotension
- 99140 Anesthesia complicated by emergency conditions

The Health Plan will determine when there may be a mutually exclusive relationship with the reported base anesthesia code.
CPT 99140 is eligible for separate reimbursement for emergency services. However, when 99140 is reported for an unscheduled routine obstetric delivery with one of the diagnosis codes listed within the related coding section below, 99140 will **not** be eligible for separate reimbursement.

VI. Anesthesia for Oral Surgery
The Health Plan allows reimbursement for anesthesia for covered oral surgical procedures reported with appropriate CDT based anesthesia codes (D9210 – 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 D9210 – D9248 will not be eligible for separate reimbursement when reported with CPT procedure codes

The Health Plan 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. Only the covered 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, the Health Plan 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

The Health Plan 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. The Health Plan considers the provision of any medication, including Propofol, to be included under the facility's charge.

The Health Plan 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, the Health Plan 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), the Health Plan 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.
- 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.

- The Health Plan 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
Diagnosis codes not eligible for reimbursement when reported with add-on code 99140	Diagnosis codes not eligible for reimbursement with reported with add-on code 99140

Policy History

09/22/2021	Review: Updated language and removed the word up from the Time section to align with configuration
11/25/2020	Biennial review approved; minor administrative updates; update to definition section
06/01/2019	Policy Template updated.
11/16/2018	Biennial Review: Updated policy language in all sections
02/07/2017	Revised: • Deleted duplicate entries of routine maternity diagnoses O34.21 and O82 and put codes in sequential order. • Remove deleted codes and add 2017 codes for spinal injections (62320-62327) under "Pain Management" section; no change to editing concept
09/06/2016	Revised: 1. Minor language updates such has clarifying that services reported by both MD and midlevel will not allow more than 100% of allowable amount 2. Removing ICD-9 codes 3. Including descriptions of CPT codes and modifiers where none existed 4. Removing 64412 under post-op pain management section; code deleted in 2016
01/05/2016	Revised: Adding 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; 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	Revised: Including 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 percents; we are removing the line under the

	modifier table that states these modifiers may be reported in a subsequent modifier field
05/05/2015	Revised: Pg. 10 1) Updating 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 2) Also on the same page, bullet 6.d., updating the grammar for professional provider separately reporting charges for medication in a facility setting, the medication is not eligible for reimbursement 3) Making the diagnosis table a little cleaner (as was done in the Routine OB policy presented last month)
11/04/2014	Revised: 1. Update name of policy to add "Services" to the title (Anesthesia Services) 2. Updating language under the Servicing Modifiers section on pg. 2; does not change any criteria or edits 3. On Pg. 3, we are adding information that we require modifiers AA, AD, QK, QX, QY, or QZ be listed in the first modifier field of the claim; these are our pay percent modifiers for anesthesia and by having these modifiers in the first modifier field ensures we apply the correct pay percent for services identified with these modifiers 4. Under section V for "Anesthesia for Oral Surgery," making some language updates to paragraph 2 on pg. 9; again, no criteria or edit changes 5. Under section 6 d on pg. 10, updating the language that states we do not reimburse medication reported by a professional provider in a facility place of service; no criteria or edit changes 6. Under section 7 on pg. 10 for Pain Management, updating language 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	Revised: Updating 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	Revised: 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. 9th bullet under 6a)—reversed the spelling out of Electroencephalogram and abbreviation of EEG • Other minor punctuation corrections
03/05/2013	Revised: • 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 • Update 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)… • Update language on pg. 7, section 7d: The Health Plan considers the provision of any medication, including Propofol, to be included under the facility's charge. Therefore, if a medication is separately reported by ~~a~~ 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	Annual Review: Revised: • 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 capnograpy 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	Revised: Footnote #s corrected
09/13/2011	Revised: • #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	Revised: • The wording in the1st 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	Revised: Updated footnote reference from RV Guide from 2009 to 2010
06/07/2011	Revised: • 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 diagnoses added V23.85-V23.89 to match the recent decision for the OB policy regarding "normal pregnancy"
03/08/2011	Revised: Accepted formatting changes to eliminate mark-ups but no wording changes made
10/05/2010	Revised: • 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	Revised: • Code range in Section 7c. was changed to 93317 and an asterisked sentences was added that 93318 is a 0 superscript code and 59 will not override edit
07/06/2010	Revised: • 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", "the Health Plan 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	Revised:

	Do not report 01996 with a physical status modifier or qualifying circumstances code. Therefore, • 3rd paragraph was added to section #2.b., and • an asterisk note was added to section #4.2nd paragraph. • Footnote #3 was added for sourcing
09/14/2009	Revised: Updated heading and policy history section with new format.
04/17/2009	Revised: The wording changes made where the usually grammatical revisions and more correctly stated policy statements.
02/03/2009	Initial policy approval and effective date

References and Research Materials

This policy has been developed through consideration of the following:

- American Medical Association (AMA) Current Procedural Terminology (CPT®) Professional Edition 2020
- American Association of Professional Coders HCPCS Level II Expert 2020

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 single unit rate used in the calculation for anesthesia reimbursement
General	Anesthesia affecting the entire body and accompanied by a loss of consciousness
Local	Loss of sensation in a limited and superficial (i.e. surface) area of the body
Regional	Loss of all forms of sensation of a particular region of the body
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 Surgery

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.