In the event of a conflict between a Clinical Payment and Coding Policy and any plan document under which a member is entitled to Covered Services, the plan document will govern. Plan documents include but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents.

In the event of a conflict between a Clinical Payment and Coding Policy and any provider contract pursuant to which a provider participates in and/or provides Covered Services to eligible member(s) and/or plans, the provider contract will govern.

Providers are responsible for accurately, completely, and legibly documenting the services performed including any preoperative workup. The billing office is expected to submit claims for services rendered using valid codes from the Health Insurance Portability and Accountability Act (HIPPA) approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing (UB) Editor, American Medical Association (AMA), Current Procedural Terminology (CPT®), CPT® Assistant, Healthcare Common Procedure Coding System (HCPCS), National Drug Codes (NDC), Diagnosis Related Group (DRG) guidelines, American Society of Anesthesiologists (ASA), Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS guidelines. Claims are subject to the code auditing protocols for services/procedures billed.

Anesthesia Clinical Payment and Coding Information

Policy Number: CPCP010

Version: 1.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: 03/08/2019

Effective Date: February 1, 2019 (Blue Cross and Blue Shield of Texas Only)

This Clinical Payment and Coding policy was created to serve as a general reference guide for anesthesia services. It is the responsibility of providers to ensure the codes that are billed accurately convey the health care services that are being provided. This policy does not address all situations that may occur and in certain circumstances these situations may override the criteria within this policy.

Modifications to this Clinical Payment and Coding policy may be made at any time. Any updates will result in an updated publication of this policy.

Description:

This policy has been developed in conjunction with the guidelines from the American Medical Association (AMA), the American Society of Anesthesiologists (ASA) and the Centers for Medicare & Medicaid Services (CMS).

Services involving administration of anesthesia should be reported by the use of the Current Procedural Terminology (CPT) anesthesia five-digit procedure codes, or CPT surgical codes plus an appropriate modifier.

An anesthesiologist or a Certified Registered Nurse Anesthetist (CRNA) can provide anesthesia services. When an anesthesiologist provides medical direction to the Certified Registered Nurse

Anesthetist (CRNA), both the anesthesiologist and the CRNA should bill for the appropriate component of the procedure performed, as applicable under state and federal law. Each provider should use the appropriate anesthesia modifier.

In keeping with the American Medical Association Current Procedural Terminology (CPT) Book, services involving administration of anesthesia include the usual pre-operative and post-operative visits, the anesthesia care during the procedure, and the administration of fluids and/or blood and the usual monitoring services (e.g., ECG, temperature, blood pressure, oximetry, capnography and mass spectrometry). Intra-arterial, central venous, and Swan-Ganz catheter insertion are allowed separately.

Reimbursement Information:

This policy applies to anesthesia services that are billed using the CMS 1500 Health Insurance Claim Form.

This policy applies to all products, in network physicians and other qualified health care professionals.

There are a number of factors utilized in determining the payment for an anesthesia service. These factors include, but are not limited to, modifiers, time units, base units, and conversion factors.

Anesthesia procedure codes may be eligible for payment based on time and points methodology, according to the definitions of time and points below. In the event anesthesia services are being utilized for multiple surgical procedures, the anesthesia procedure code for the most complex service should be billed.

NOTE: Not all anesthesia procedure codes are paid based on time and points methodology. Claims are subject to the code auditing software in use for the date of service billed and subject to the terms and conditions of the provider contract.

Anesthesia Modifier Information

Any anesthesia services when performed by various specialties could require an anesthesia modifier to identify whether the service was personally performed, medically supervised, or under medical direction.

The table below provides the pricing modifiers that are required to be billed in the first modifier position.

	Modifier	Description
Modifier Information Billed by an Anesthesiologist	AA	Anesthesia services personally performed by the anesthesiologist
	AD	Supervision, more than four procedures
	QK	Medical Direction of two, three or four concurrent anesthesia procedures
	QY	Medical Direction of one CRNA by an anesthesiologist
Modifier Information Billed by a CRNA	**Modifier**	**Description**
	QX	Anesthesia, CRNA medically directed
	QZ	Anesthesia, CRNA not medically directed

Physical Status Modifiers

The American Society of Anesthesiologists (ASA) and CPT guidelines list six levels of patient physical status modifiers. Adding a physical status modifier to a time-based anesthesia code classifies the level of complexity. In more complex situations, modifying unit(s) are added to the base unit value.

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

Informational Only Modifiers

The following five modifiers (QS, G8, G9, 23, 47) are considered informational only. These modifiers should be billed in the second modifier position when a pricing anesthesia modifier accompanies it in the first modifier position and the service rendered is monitored anesthesia care (MAC).

Informational Only Modifiers	Description
QS	Monitored anesthesia care service (MAC)
G8	Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure
G9	Monitored anesthesia care (MAC) for a patient who has a history of severe cardiopulmonary condition
23	Unusual Anesthesia
47	Anesthesia by Surgeon

Payment Calculation

Time units plus base points plus unit value(s) allocated to physical status modifiers and/or qualifying circumstances listed below (if applicable) equals "Y". Allowable amount equals the anesthesia conversion factor multiplied by "Y".

Allowed from Time and Points = (Time Units + Base Units + Physical Status Modifier) x Conversion Factor

Allowed from Qualifying Circumstances = Qualifying Circumstance Value x Conversion Factor

Time

Anesthesia time begins when the provider of services physically starts to prepare the patient for induction of anesthesia in the operating room (or equivalent) and ends when the provider of services is no longer in constant attendance and the patient may safely be placed under postoperative supervision.

Base Points

The basis for determining the base points is the Relative Value Guide published by the American Society of Anesthesiologists (ASA). Base points used to process claims will be the base points in effect on the date(s) covered services are rendered. The exception to this will be covered services provided on dates between the receipt of the Relative Value Guide published by the ASA and implementation of the updated material. Newly established codes will be paid at the determined rates until any update is implemented.

Qualifying Circumstances

Qualifying Circumstances Add-on procedure codes are conditions that significantly impact the anesthetic service that is being provided and should only be utilized in conjunction with the anesthesia service with the highest Base Unit Value. Please refer to the payment calculation formula above.

Qualifying Circumstances to be billed by anesthesiologists and/or CRNAs	CPT	Description	Unit Value(s)
	99100	SPECIAL ANESTHESIA SERVICE	1
	99116	ANESTHESIA WITH HYPOTHERMIA	5
	99135	SPECIAL ANESTHESIA PROCEDURE	5
	99140	EMERGENCY ANESTHESIA	2

Daily Hospital Management of Epidural or Subarachnoid Continuous Drug Administration

CPT code 01996 is not allowed on the day of the operative procedure. Only one (1) unit of service (not base units) will be allowed each day.

Limitations and Exclusions

Certain procedure codes may be excluded from the methodology above; refer to specific fee schedules. When duplicate anesthesia services are billed by the same physician, different physician, or other qualified health care professional for the same patient, on the same date of service, the claim will be denied.

Note: Reimbursement for CPT code 00104 is not allowed when anesthesia is performed by a Psychiatrist (or other qualified healthcare professional) in addition to Electroconvulsive therapy (ECT) services (CPT 90870).

References:

American Association of Anesthesiologists (ASA). Retrieved May 25, 2017, from https://www.asahq.org/

American Medical Association (AMA). Current Procedural Terminology (CPT). Retrieved May 25, 2017, from https://www.ama-assn.org/

Centers for Medicare & Medicaid Services (CMS). Retrieved May 25, 2017, from https://www.cms.gov/

Policy Update History:

Approval Date	Description
10/11/2017	New policy
12/06/2017	Revised
09/28/2018	Annual Review
03/08/2019	CPT Code descriptor update