Anesthesia Services

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DESCRIPTION:

Anesthesia services consist of the administration of an anesthetic agent, typically by injection or inhalation, causing partial or complete loss of sensation, with or without loss of consciousness.

These services are provided as one of the following types of anesthesia:

- Regional – the use of local anesthetic agents to produce circumscribed areas of loss of sensation. Regional anesthesia can include nerve blocks, spinal, epidural, and field blocks. Epidural anesthesia is produced by injection of local anesthetic agent into the peridural space.
- Local – infiltration or topical application of an anesthetic agent at or near the site where the procedure is to be performed, creating loss of sensation to the area
- General – loss of the ability to perceive pain, associated with loss of consciousness, produced by intravenous infusion of drugs or inhalation of anesthetic agents
- Monitored Anesthesia Care (MAC) – intraoperative monitoring by a physician or other qualified individual under the medical direction of the physician, of the patient’s vital physiological signs in anticipation of the need for administration of general anesthesia or of the development of adverse physiological patient reaction to the surgical procedure.
- Moderate sedation - Moderate (conscious) sedation is defined by the American Society of Anesthesiologists as a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

NOTE: Moderate sedation is not discussed in this policy but is addressed in a separate policy.
**REIMBURSEMENT INFORMATION:**

Anesthesia services are **eligible for coverage** when:

- the procedure for which the anesthesia is administered is a covered service
- the anesthesia is administered by a:
  - physician (other than the operating physician, assistant surgeon, or obstetrician) qualified to administer general anesthesia or to appropriately supervise anesthesia, OR
  - certified registered nurse anesthetist (CRNA), OR
  - anesthesiologist assistant (AA)

The usual preoperative and post operative visits and consultations, the anesthesia care during the procedure, the administration of fluids and/or blood, and the usual monitoring services (e.g., ECG, temperature, blood pressure, oximetry, capnography and mass spectrometry) are included in the reimbursement for the anesthesia service. Unusual forms of monitoring (e.g., intra-arterial, central venous, and Swan-Ganz) are not included and are reimbursed separately.

Pre-operative care, post-operative care, or consultations provided by the anesthesiologist for care other than normal or uncomplicated care (e.g., pain management), may be eligible for coverage if separately identifiable services were rendered. Substantiating documentation would be required for medical review of medical necessity (e.g., physician history and physical, physician progress notes, physician operative notes).

Additionally, the following procedures and services are considered as integral components of general anesthesia and are not reimbursed separately:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>31500</td>
<td>Intubation, endotracheal, emergency procedure</td>
</tr>
<tr>
<td>31505</td>
<td>Laryngoscopy, indirect; diagnostic (separate procedure)</td>
</tr>
<tr>
<td>31515</td>
<td>Laryngoscopy direct; with or without tracheoscopy, for aspiration</td>
</tr>
<tr>
<td>31527</td>
<td>Laryngoscopy direct; with insertion of obturator</td>
</tr>
<tr>
<td>31622</td>
<td>Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance; diagnostic, with or without cell washing (separate procedure)</td>
</tr>
<tr>
<td>36000</td>
<td>Introduction of needle or intracatheter, vein</td>
</tr>
<tr>
<td>36430</td>
<td>Transfusion, blood or blood components</td>
</tr>
<tr>
<td>92950</td>
<td>Cardiopulmonary resuscitation (e.g., in cardiac arrest)</td>
</tr>
<tr>
<td>92953</td>
<td>Temporary transcutaneous pacing</td>
</tr>
<tr>
<td>92960</td>
<td>Cardioversion, elective, electrical conversion of arrhythmia, external</td>
</tr>
<tr>
<td>93000–93010</td>
<td>Electrocardiogram, routine ECG with at least 12 leads</td>
</tr>
<tr>
<td>93040–93042</td>
<td>Rhythm ECG, one to three leads</td>
</tr>
<tr>
<td>93922</td>
<td>Noninvasive physiologic studies of upper or lower extremity arteries, single level, bilateral (e.g., ankle/brachial indices, Doppler waveform analysis, volume plethysmography, transcutaneous oxygen tension measurement)</td>
</tr>
<tr>
<td>93923</td>
<td>Noninvasive physiologic studies of upper or lower extremity arteries, multiple levels or with provocative functional maneuvers, complete bilateral study (e.g., segmental blood pressure measurements, segmental Doppler waveform analysis, segmental volume plethysmography, segmental transcutaneous oxygen tension measurement, measurements with postural provocative tests, measurements with reactive hyperemia)</td>
</tr>
</tbody>
</table>
Monitored anesthesia care (identified by the -QS modifier) is **eligible for coverage** when performed by the anesthesiologist, CRNA or qualified anesthetist under the medical direction of a physician, and includes all of the following criteria:

- requested by the attending physician/operating surgeon
- performance of a pre-anesthetic examination and evaluation
- prescription of the anesthesia care required
- administration of necessary oral and parenteral medications
- personal participation in, or medical direction of, the entire plan of care
- continuous physical presence of the anesthesiologist or, in the case of medical direction, of the qualified anesthetist (i.e., CRNA, AA) being medically directed (must be present in the operating suite during operative procedure) or proximate presence (within vicinity of the operating suite) or (in the case of medical direction) availability of the anesthesiologist for diagnosis or treatment of emergencies
- usual non-invasive cardiovascular and respiratory monitoring
- oxygen administration, when indicated
- intravenous administration of sedatives, tranquilizers, anti-emetics, narcotics, other analgesics, beta-blockers, vasopressors, bronchodilators, anti-hypertensives, or other pharmacologic therapy as may be required in the judgment of the anesthesiologist.

Reimbursement for monitored anesthesia care is limited to one provider (anesthetist or anesthesiologist) per day.

**Non-covered Anesthesia Services**
The following anesthesia services are NOT eligible for coverage:

- anesthesia by hypnosis
- anesthesia by acupuncture
- anesthesia for cosmetic surgery
- standby, non-active participation for anesthesiology during surgery.
Positioning of the Patient
Positioning the patient (e.g., lithotomy, lateral, prone, sitting, field avoidance) before, during, or following a therapeutic procedure, is considered incidental to other services provided and is not reimbursed separately.

Qualifying Circumstances for Anesthesia
Reimbursement for Qualifying Circumstances for Anesthesia (99100-99140) is included in the basic allowance for other anesthesia procedures (00100-01999), when performed on the same day by the same provider.

Local anesthesia
Local anesthesia is considered to be an integral part of the surgical procedure and no additional reimbursement is provided.

Multiple Surgical Procedures
When multiple surgical procedures are performed, the base value of anesthesia is the base value for the procedure with the highest relative unit value. No reimbursement is provided for the base unit values of additional procedures. Time units cover the additional time required for these procedures.

Pre-anesthesia Evaluation
A pre-anesthesia evaluation by the anesthesiologist when surgery is canceled may be covered at the level of care rendered (e.g., brief or limited visit) as a hospital or office visit.

A pre-anesthesia evaluation by the anesthesiologist when the procedure is delayed is not eligible for coverage as a separate procedure. It is an integral part of the subsequent anesthesia services.

Anesthesia Administered by the Operating Surgeon
Reimbursement for general anesthesia or intravenous analgesia administered by the operating surgeon, assistant surgeon, or obstetrician is included in the basic allowance for the surgical procedure performed.

Transsesophageal Echocardiography
In accordance with the correct coding initiative, effective October 23, 2008, Transesophageal Echocardiography (TEE) Placement and Interpretation is no longer considered for separate reimbursement in addition to payment for the primary anesthesia procedure. However, when this service is performed for diagnostic purposes and documentation is provided to include a formal report, this service may be considered for separate reimbursement in accordance with CMS guidelines.

Ventilation Management
Ventilation Assist and Management is a covered service. This service is not necessarily confined to the critical care area. It can be rendered in a hospital setting, or in rare cases rendered in extended care facilities or the home setting. Reimbursement for initial ventilation and management is limited to one within a 30-day period. Effective January, 2007, Ventilation Assist and Management is incidental to the anesthesia service when it is performed on the same day as the anesthesia.

Epidurals
Epidural analgesia involves the administration of a narcotic drug through an epidural catheter. When performed as the primary type of anesthesia, the time required is included in the total anesthesia minutes reported.

A continuous epidural reported using procedure code 62319 is reimbursed only one time, as a flat rate code.
Daily hospital management of epidural or subarachnoid continuous drug administration (01996) is limited to one service per day on subsequent days. This code is reimbursed at a rate of three times the anesthesia conversion factor. There are no time units involved in the reimbursement calculation.

**Labor Epidurals**
Anesthesia for labor epidurals are time based services and should be billed as total minutes.

01967: Vaginal delivery with epidural for pain management. Code may be reported as a single anesthesia service. Depending on the terms of the participating provider agreement, reimbursement may be based on base units plus time units (insertion through delivery) subject to a maximum time of 7 hours or 420 minutes. This change is effective for dates of service on or after July 1, 2010.

01968: Cesarean delivery following failed attempt at vaginal delivery. This is an add-on code and should always be reported with 01967.

01969: Cesarean delivery followed by a cesarean hysterectomy after failed planned vaginal delivery. This is an add-on code and should always be reported with 01967.

**Medical Direction**
Medical direction of a qualified anesthetist (CRNA) by the anesthesiologist may be covered when the anesthesiologist

- remains physically present in the operating suite and available for immediate diagnosis and treatment of emergencies,
- does not personally administer an anesthetic to another patient while medically directing,
- directs not more than four (4) anesthetists performing concurrent procedures,
- performs a pre-anesthetic examination and evaluation,
- prescribes the anesthesia plan,
- personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence,
- ensures that procedures not performed by the anesthesiologist are performed by a qualified individual,
- monitors the course of anesthesia administration at frequent intervals, **AND**
- provides indicated post-anesthesia care.

**NOTE:** A physician who is concurrently directing the administration of anesthesia to 1-4 patients should not typically be involved in providing services to other patients except in the following situations:

- Addressing an emergency of short duration in the immediate area
- Administering an epidural or caudal anesthetic to ease labor pain or periodic (rather than continuous) monitoring of an obstetrical patient
- Receiving patients entering the operating suite for the next surgery
- Checking or discharging patients in the recovery room
- Handling scheduling matters.

**Medical Supervision vs. Medical Direction**
When the anesthesiologist does not fulfill all of the "medical direction" requirements listed above, the concurrent anesthesia services are considered medical supervision services and are not considered medical direction services. Reimbursement for medical **supervision** is included in the hospital ancillary services.


**Reporting Time Units**
The period of time on which anesthesia time units are based begins when the anesthesiologist is first in attendance with the patient for the purpose of induction of anesthesia, and ends when the patient leaves the operating room or delivery room. Time spent in the recovery room is included in the anesthesia base units and no additional reimbursement is provided.

**Reimbursement Calculation**
Anesthesia time should be submitted on the claim as total minutes. For example, 1 hour and 9 minutes of anesthesia time is billed as 69 minutes. The total minutes should be placed in field 24G of the CMS1500 claim form. BCBSF then converts minutes into 15 minute increments. If a fraction is left over (less than 15 minutes), this amount will be rounded up to the next 15 minute increment or a fraction thereof.

Effective July 1, 2010, Florida Blue will round the time units to the nearest tenth of a unit if the provider’s participating agreement provides for the billing of time units or a fraction thereof. All other contracted providers will continue to have their time units rounded up to the next 15 minute increment.

**Reimbursement for Time Based Services with Anesthesia Modifiers**
The following modifiers are utilized by the system to determine payment to the provider. One of these modifiers must be associated with the time based anesthesia code in order for the line to be appropriately adjudicated.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Modifier Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA</td>
<td>100%</td>
</tr>
<tr>
<td>QZ</td>
<td>100%</td>
</tr>
<tr>
<td>QK</td>
<td>50%</td>
</tr>
<tr>
<td>QX</td>
<td>50%</td>
</tr>
<tr>
<td>QY</td>
<td>50%</td>
</tr>
</tbody>
</table>

Anesthesia Performed by Anesthesiologist or CRNA (AA, QZ Modifier):

\[
(Base \ Factor + Total \ Time \ Units) \times \text{Anesthesia Conversion Factor} = \text{Allowance}
\]

Anesthesia Performed under Medical Direction (QK, QX and QY modifiers):

\[
[(Base \ Factor + Total \ Time \ Units) \times \text{Anesthesia Conversion Factor}] \times \text{Modifier Adjustment} .50 = \text{Allowance for each provider}
\]

**BILLING/CODING INFORMATION:**

The following CPT procedure codes may be used to describe anesthesia services:

**CPT Coding:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00100 – 01999</td>
<td>Anesthesia (site specific)</td>
</tr>
<tr>
<td>99100*</td>
<td>Anesthesia for patient of extreme age, under one year and over seventy (List separately in addition to code for primary anesthesia procedure)</td>
</tr>
</tbody>
</table>

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1 PPM refined calculation is applied to participating providers that have had contractual notification.
<table>
<thead>
<tr>
<th>CPT Code*</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99116*</td>
<td>Anesthesia complicated by utilization of total body hypothermia (List separately in addition to code for primary anesthesia procedure)</td>
</tr>
<tr>
<td>99135*</td>
<td>Anesthesia complicated by utilization of controlled hypotension (List separately in addition to code for primary anesthesia procedure)</td>
</tr>
<tr>
<td>99140*</td>
<td>Anesthesia complicated by emergency conditions (specify) (List separately in addition to code for primary anesthesia procedure)</td>
</tr>
</tbody>
</table>

*NOTE: Qualifying Circumstances for Anesthesia is included in the basic allowance for anesthesia procedures.

**CPT Modifiers:**

- **47** Anesthesia by surgeon
- **P1** A normal healthy patient
- **P2** A patient with mild systemic disease
- **P3** A patient with severe systemic disease
- **P4** A patient with several systemic disease that is a constant threat to life
- **P5** A moribund patient who is not expected to survive without the operation
- **P6** A declared brain-dead patient whose organs are being removed for donor purposes

**NOTE:** Additional reimbursement is not provided for the physical status (P) modifiers

**HCPCS Coding/Modifiers:**

- **AA** Anesthesia services performed personally by anesthesiologist
- **AD** MD supervision, more than 4 anesthesia services
- **G8** Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure
- **G9** Monitored anesthesia care for patient who has history of severe cardiopulmonary condition
- **QK** Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals
- **QS** Monitored anesthesia care service
- **QX** CRNA service; with medical direction by a physician
- **QY** Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist
- **QZ** CRNA service; without medical direction by a physician

**PROGRAM EXCEPTIONS:**

- **Federal Employee Program (FEP):** Follow FEP guidelines.
- **State Account Organization (SAO):** Follow SAO guidelines.
DEFINITIONS:

No policy specific definitions apply.

RELATED PAYMENT POLICIES:

Moderate Sedation Payment Policy

OTHER:

Florida Statute 627.4295 Dental procedures; anesthesia and hospitalization coverage –

For purposes of this section, dental treatment or surgery shall be considered necessary when the dental condition is likely to result in a medical condition if left untreated. Any individual health insurance policy issued or issued for delivery in this state which provides coverage for general anesthesia and hospitalization services to a covered person shall not preclude such coverage in assuring the safe delivery of necessary dental care provided to a covered person who:

- Is under 8 years of age and is determined by a licensed dentist, and the child's physician licensed under chapter 458 or chapter 459, to require necessary dental treatment in a hospital or ambulatory surgical center due to a significantly complex dental condition or a developmental disability in which patient management in the dental office has proved to be ineffective; or

- Have one or more medical conditions that would create significant or undue medical risk for the individual in the course of delivery of any necessary dental treatment or surgery if not rendered in a hospital or ambulatory surgical center.

As provided herein, all terms and conditions of the covered person's health insurance policy shall apply to such services, and this section does not require coverage for the diagnosis or treatment of dental disease. An insurer may require prior authorization for general anesthesia and hospital services required under this section in the same manner the insurer requires prior authorization for hospitalization for other covered services. This section shall not apply to Medicare supplement, long-term care, disability, limited benefit, accident only, or specified disease policies.

REFERENCES:

2. American Society of Anesthesiologists. ASA physical status classification system.
8. Blue Cross Blue Shield Association Medical Policy - Anesthesia Services 10.01.06 (05/30/97).
12. The Florida Medicare B Update; Third Quarter 2002; Anesthesia, p. 13.

COMMITTEE APPROVAL:

This Payment Policy was approved by the Florida Blue Payment Policy Committee on 09/08/08. This revised Payment Policy was approved by the Florida Blue Payment Policy Committee on 05/21/10.

PAYMENT POLICY UPDATE INFORMATION:

<table>
<thead>
<tr>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/15/08</td>
<td>New payment policy.</td>
</tr>
<tr>
<td>12/22/09</td>
<td>Revision</td>
</tr>
<tr>
<td>05/21/10</td>
<td>Revision</td>
</tr>
<tr>
<td>05/31/12</td>
<td>Revision – Changed name from BCBSF to Florida Blue</td>
</tr>
</tbody>
</table>

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