SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.5 ANESTHESIA

This is a subsection of Section 5: Billing and Reimbursement Guidelines of the *Professional Provider Office Manual*. If we make any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this subsection and notify our network providers. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.bcbsla.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.bcbsla.com/providers.

This manual is provided for informational purposes only and is an extension of your Professional Provider Agreement. You should always directly verify member benefits prior to performing services. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent. The Member Contract/Certificate contains information on benefits, limitations and exclusions, and managed care benefit requirements. It also may limit the number of days, visits or dollar amounts to be reimbursed.

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ANESTHESIA

Definitions

- Anesthesia - the introduction of a substance into the body by external or internal means that causes loss of sensation (feeling) with or without loss of consciousness.
- Anesthesiologist - a physician (M.D. or D.O.) who specializes in anesthesiology.
- Certified Registered Nurse Anesthetist (CRNA) - a registered nurse who is licensed by the state in which the nurse practices. The CRNA must be certified by the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists or the CRNA must have graduated within the past 24 months from a nurse anesthesia program that meets the standards of the Council on Accreditation of Nurse Anesthesia educational programs and be awaiting initial certification.
- Concurrent Medically Directed Anesthesia Procedures - concurrency is defined with regard to the maximum number of procedures that the physician is medically directing within the context of a single procedure and whether these other procedures overlap one another. The physician can medically direct two, three or four concurrent procedures involving qualified CRNAs.
- Medical Direction - occurs when an anesthesiologist is involved in two, three or four concurrent anesthesia procedures or a single anesthesia procedure with a qualified CRNA.
- Medical Supervision - occurs when an anesthesiologist is involved in five or more concurrent anesthesia procedures.

Personally Performed Anesthesia

We will determine the applicable allowable charge, recognizing the base unit for the anesthesia code and one time unit per 15 minutes of anesthesia time (unless otherwise stated) if:

- The physician personally performed the entire anesthesia service alone;
- The physician is continuously involved in a single case involving a student nurse anesthetist; or,
- The physician and the CRNA are involved in one anesthesia case and the services of each are found to be medically necessary upon appeal. Documentation must be submitted by both the CRNA and the physician to support payment of the full fee for each of the two providers through our appeal process. The physician reports Modifier AA and the CRNA reports Modifier QZ for a non-medically directed case.

Medical Direction

We will determine payment for the physician's medical direction service on the basis of 60% of the allowable charge for the service performed by the physician alone. Medical direction occurs if the physician medically directs qualified CRNAs in two, three or four concurrent cases and the physician performs the following activities that must be documented in the anesthesia record:

- Performs a pre-anesthetic examination and evaluation;
- Prescribes the anesthesia plan;

- Personally participates only in the most demanding procedures in the anesthesia plan, when clinically appropriate;
- Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist;
- Monitors the course of anesthesia administration at frequent intervals;
- Remains physically present and available in the operating room and/or recovery areas for immediate diagnosis and treatment of emergencies; and
- Provides indicated post-anesthesia care.

If the physician is involved with a single case with a CRNA, we will pay the physician service and the CRNA service in accordance with the medical direction payment policy outlined in these guidelines.

If anesthesiologists are in a group practice, one physician member may provide the pre-anesthesia examination and evaluation while another fulfills the other criteria. Similarly, one physician member of the group may provide post-anesthesia care while another member of the group furnishes the other component parts of the anesthesia service. The medical record must indicate that the services were furnished by physicians and identify the physician(s) who furnished them.

A physician who is concurrently directing the administration of anesthesia to not more than four surgical patients cannot ordinarily be involved in furnishing additional services to other patients. However, 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, does not substantially diminish the scope of control exercised by the physician in directing the administration of anesthesia to surgical patients. It does not constitute a separate service for the purpose of determining whether the medical direction criteria are met. Further, while directing concurrent anesthesia procedures, a physician may receive patients entering the operating suite for the next surgery, check or discharge patients in the recovery room, or handle scheduling matters without affecting fee schedule payment.

If the physician leaves the immediate area of the operating suite for other than short durations, devotes extensive time to an emergency case or is otherwise not available to respond to the immediate needs of the surgical patients, the physician's services to the surgical patients are supervisory in nature and would not be considered medical direction.

Filing Claims

Anesthesia services by anesthesiologists or CRNAs must be filed using the appropriate anesthesia CPT code (beginning with the zero). One of the modifiers listed in this section must be submitted with each anesthesia service billed. Failure to submit one of the modifiers will result in a returned or rejected claim.

The allowable charge for medically necessary anesthesia services will be determined based on the applicable anesthesia conversion factor and the modifier submitted on the claim. The applicable anesthesia modifier will determine what percentage of the anesthesia conversion factor is to be applied to each claim, without regard to the order in which claims are received for both anesthesiologists and CRNAs.

To ensure proper reimbursement when billing for anesthesia services, anesthesiologists and CRNAs must include:

1. Number of minutes of administration
2. CPT anesthesia (00100-01999) codes with one of the required modifiers listed in this section
3. American Society of Anesthesiologists (ASA) modifier code(s) for physical status and CPT codes appropriate for qualifying circumstances (see further in this section for details), if appropriate
4. Proper identification by including any performing provider(s) NPI on the claim form

Required Modifiers - Anesthesiologist (M.D. or D.O.)

Modifier	Modifier Description	Reimbursement
AA	Anesthesia services personally performed by an anesthesiologist.	100% of allowable charge
AD	Medical supervision by a physician; more than four concurrent anesthesia procedures or is performing other services while directing the concurrent procedures.	3 base units with no additional units allowed for physical status modifiers, qualifying circumstances, or time
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified CRNAs.	60% of allowable charge
QY	Medical direction of one CRNA by an anesthesiologist.	60% of allowable charge

Required Modifiers - CRNA

Modifier	Modifier Description	Reimbursement
QX	Billed by CRNA when providing the anesthesia service while being medically directed by an anesthesiologist.	40% of allowable charge
QZ	Billed by CRNA when providing anesthesia services without medical direction by an anesthesiologist.	100% of allowable charge

Listing of Acceptable and Non-acceptable Modifiers for Subsequent Claims

Refer to this list when including the following modifiers, either on the same claim but on different service line(s) (in a group billing situation), or on a separate claim from a different provider.

First Claim Received for Payment Consideration	Acceptable Modifiers for Subsequent Claims	Non-acceptable Modifiers for Subsequent Claims
Performing provider No. 1 bills one of these modifiers.	Performing provider No. 2 bills one of these modifiers on a separate claim or separate service line item on the same claim.	No additional claim will be paid with these modifiers.
AA		AA, AD, QK, QX, QY, QZ
QZ		AA, AD, QK, QX, QY, QZ
AD	QX	AA, AD, QK, QY, QZ
QK	QX	AA, AD, QK, QY, QZ
QY	QX	AA, AD, QK, QY, QZ
QX	AD, QK, QY	AA, QX, QZ

Please Note: Our claims processing system edits all anesthesia claims for the appropriate use of modifiers. Should we receive a subsequent claim with inconsistent modifiers when comparing to the initial claim received, the subsequent claim will be denied. For example, if an initial claim is filed with Modifier AA indicating the service was personally performed by a physician, and a subsequent claim is received with Modifier QX indicating that a CRNA was involved in the anesthesia service, the initial claim would be the only claim expected; therefore, the CRNA claim would be denied or returned due to the inconsistent modifier. Further, if the anesthesia record reflects that more than one anesthesia provider was involved in the case, the provider who received the returned or denied claim should appeal the denial. When filing the appeal, the anesthesia record must be included as supporting documentation to justify a different reimbursement. If a decision is made to overturn the appeal in this scenario, a recoupment would be requested on the claim allowed at 100% in order to apply the appropriate payment split to both providers involved in performing the anesthesia service.

Base Units

The base unit is the value assigned to each CPT code and includes all usual services except the time actually spent in anesthesia care and the qualifying factors. This usually includes pre-op and post-op visits. When multiple anesthesia services are performed, only the anesthesia service with the highest base unit value should be filed with total time for all services reported on the highest base unit value code. The base units value should never be entered in the "units" field on the claim form.

Anesthesia Time and Calculation of Time Units

Anesthesia time is defined as the period during which an anesthesia practitioner is present with the patient. We consider anesthesia time to begin when the anesthesiologist or CRNA begins to prepare the patient for anesthesia care in the operating room or in an equivalent area and ends when the anesthesiologist or CRNA is no longer in personal attendance, that is, when the patient is safely placed under post-anesthesia supervision.

Anesthesia time must be reported in minutes. Failure to include anesthesia time may result in the claim being either returned or denied. If anesthesia time is reported in units, incorrect payment will result. Minutes will be converted to units by assigning one unit to each 15 minutes (exception is CPT 01967, which is based on a 60-minute unit). Time units will be rounded to two decimal places (exception is CPT 01967, which is rounded to four decimal places).

No additional time units are payable for add-on codes; therefore, total time must be reported on the primary procedure code. In the case where multiple procedures are performed, time for lower base unit value codes should be reported on the highest base unit value code.

Please Note: We do not recognize time units for CPT 01996 (see Pain Management section on the next page). The physician who medically directs the CRNA would ordinarily report the same time as the CRNA reports for the CRNA service.

Blue Cross/HMO Louisiana time calculation examples:

- Code 00790 for 50 minutes = 3.33 time units
- Code 01967 for 311 minutes = 5.1833 time units

Qualifying Factors

Physical Status

If physical status modifiers are applicable, the modifier should be indicated on the CMS-1500 claim form (Block 24D or the equivalent field on electronic claims) by the letter P followed by a single digit from one to six. Additional units may be allowed when the claim indicates any of the following:

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

Qualifying Circumstances

When any of the CPT codes defined in this section are provided in addition to anesthesia procedures, the allowable charge is the basis for reimbursement. Do not bill these procedures with anesthesia modifiers, physical status modifiers or anesthesia minutes; otherwise, delay or rejection of payment may occur.

- Qualifying circumstances are those factors that significantly affect anesthesia services. Examples are the extraordinary condition of the patient, notable operative conditions and unusual risk factors. These procedures would not be reported alone, but as additional procedures qualifying an anesthesia procedure or service. Each qualifying circumstance is listed here: 99100, 99116, 99135, 99140.

- Specialized forms of monitoring also fall into the category of Qualifying Circumstances. Those that qualify are listed below. Although there are other forms of monitoring that are not listed here, these are the only ones for which an additional amount may be allowed. Any other charges should be combined with the total charge without an additional allowable charge. When billed in conjunction with an anesthesia procedure, the following CPT codes or combination of CPT codes are reimbursed over and above the anesthesia procedure, based on the provider's allowable charge and medical necessity.
- Arterial line (36620 or 36625)
- Central venous line (36555, 36556, 36568, 36569, 36580 or 36584)
- Swan Ganz line (93503)

Obstetrical Anesthesia/Epidural

Obstetrical anesthesia/epidural procedures are reimbursed as indicated below. An additional allowable charge for emergency conditions may apply to reimbursement for epidural anesthesia (please refer to the Qualifying Circumstances section).

Code	Units
01961	7 base units plus time units based on standard 15-minute time calculation
01967	7 units plus time units based on 60-minute time calculation
01968	3 units (no additional time allowed)

Please Note: CPT 01968 is an add-on code to CPT 01967. If a cesarean delivery is performed after neuraxial labor analgesia/anesthesia, bill CPT 01967 with total time, plus CPT 01968.

Pain Management

Pain management codes should not be billed using anesthesia modifiers, physical status modifiers or anesthesia minutes. If claims are filed as such, delay in payment or incorrect payment may occur.

Outpatient Pain Management

1. An injection of anesthetic agent and/or steroid, transforaminal epidural, lumbar or sacral, single level should be coded 64483 and paid based on the appropriate allowable charge. Code 64484 should be billed for each additional level.
2. An injection of anesthetic agent and/or steroid, transforaminal epidural, lumbar or sacral is considered a surgical procedure for benefit purposes. Surgical procedures (including nerve blocks) should be billed as "1" unit per CPT guidelines. The Base Units value should not be entered in the "units" field on your claim. The injection must be performed by an M.D. or D.O. for diagnostic or therapeutic purposes. If an injection is provided on the same day the surgery is performed, the service will be included in the base units and time charged for the administration of anesthesia. If an injection is provided on a day subsequent to the surgery, the procedure will be considered a surgical service and appropriate benefits allowed.

Post-operative Pain Management

1. **Epidural**: Daily management of epidural or subarachnoid drug administration should be coded 01996 for the professional charge, and the medication should be billed by the hospital as an ancillary charge. CPT 01996 should be utilized to bill for a pain management service when drug administration is being monitored by the provider or an injection is inserted into an existing catheter. Payment will be based on a maximum of three units per day for a maximum of three days of epidural management, including the day of surgery. Billing anesthesia minutes, anesthesia modifiers or physical status modifiers with CPT 01996 is not appropriate, and, if billed, a delay in payment or non-payment may occur.

2. **IV PCA**: Provider should bill CPT 99231* for the IV PCA daily management. The allowable charge is the basis for reimbursement. The set-up charge is included in the E&M allowance of the daily management and should not be billed separately. Billing anesthesia minutes, anesthesia modifiers or physical status modifiers with CPT 99231 is not appropriate, and, if billed, a delay in payment or non-payment may occur.

**Evaluation and Management Code 99231 is the recommended coding by the ASA and is the industry standard for this service. All components must be medically necessary and documented in the anesthesia record in order to bill this code.*

3. **Pump Setup:** The pump setup is included in the allowable charge for the daily management fee for both IV PCAs (CPT 99231) and Epidural PCAs (CPT 01996), and should not be billed separately.

4. **Nerve Block Injections**: Nerve blocks performed for postoperative pain management, provided that they are not the mode of anesthesia and are distinct procedures, are eligible for reimbursement when identified by the Modifier 59 as a distinct procedure. These services should not be included as additional anesthesia time. Reimbursement is made only for services provided by a physician/CRNA when performed outside of the intraoperative area. Postoperative pain management will be appropriate for most major intrathoracic, intra-abdominal, vascular and orthopedic procedures. The intent of the procedure should be documented as to why post-operative pain relief is not achievable through the use of alternative measures and be procedure specific as would be supported by acceptable peer-reviewed literature and guidelines. The documentation must support the medical necessity of the nerve block service performed by the anesthesiologist instead of the service being performed by the surgeon. Nerve block services will be considered for reimbursement only when there is written documentation that the surgeon has requested such a service. Surgical procedures (including nerve blocks) should be billed as "1" unit per CPT guidelines. The base units value should not be entered in the "units" field on your claim. The surgeon should manage post-operative pain except under unique circumstances. Operative notes, anesthesia procedure notes, anesthesia record and pre/post-operative orders should be available when requested to support claim review.

Clinical editing is applicable to all anesthesia services.

Claims Example

A Blue Cross member has a cholecystectomy that requires 50 minutes of anesthesia. Due to the fact that the member is over age 70, CPT 99100 is also billed. The claim submitted by the anesthesiologist to Blue Cross should include the appropriate information explained above. The claim for covered services is processed as follows to determine the allowable charge:

M.D. Personally Performed or Non Medically Directed CRNA	M.D. Medically Directing 2-4 Concurrent Procedures	Medically Directed CRNA Claim
(Base Units + Time Units + Physical Status Modifier Units) x Unit Value = Allowable Charge	[(Base Units + Time Units + Physical Status Modifier Units) x Unit Value] x 60% = Allowable Charge for each case being medically directed	[(Base Units + Time Units + Physical Status Modifier Units) x Unit Value] x 40% = Allowable Charge for each case being medically directed
CPT 00790 AA (or QZ) Base Units 7 + Time Units (50 mins.) 3.33 Total Units 10.33 x Unit Value $40* Allowable Charge $413.20	**CPT 00790 QK (or QY)** Base Units 7 + Time Units (50 mins.) 3.33 Total Units 10.33 x Unit Value $40* Subtotal $413.20 x Medically Directed 60% Allowable Charge $247.92	**CPT 00790 QX** Base Units 7 + Time Units (50 mins.) 3.33 Total Units 10.33 x Unit Value $40* Subtotal $413.20 x Medically Directed 60% Allowable Charge $247.92

*For illustration purposes only.

The Base Units value should never be included in the "units" field of your claim.

CPT 99100 (payment is based on the allowable charge) – The totals noted in each of these examples do not include the payment for the qualifying circumstance CPT 99100 that was applicable in the example. Additional reimbursement for CPT 99100 will be based on the provider's allowable charge.

If any modifiers were applicable for physical status, those units would be added to the above calculations as noted in the formulas. The allowable charges represent the total amount collectable from Blue Cross and the member (if deductible, copayment and/or coinsurance apply). The difference between the provider's charge and the allowable charge is not collectable from the member.

Documentation Requirements

All billing should be supported by the anesthesia record. Records are required with claims submissions in the following cases:

- Submission of any miscellaneous procedure codes, for example, CPT 01999. Because the code does not provide sufficient information, the record is necessary to identify the actual procedure performed.
- Anesthesia administered for dental procedures. Because dental coverage guidelines may be limited, the anesthesia record will help us to make coverage determination on each case.

- If two different anesthesia services are billed on the same claim with the same performing provider identifier (NPI), the anesthesia record is needed to document that two different operative sessions occurred on the same day.
- If a procedure is billed that is not site-specific, we may request the anesthesia record to determine the site to ensure coverage should be allowed.