If a conflict arises 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. If a conflict arises between a CPCP 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. “Plan documents” include, but are not limited to, Certificates of Health Care Benefits, benefit booklets, Summary Plan Descriptions, and other coverage documents. Blue Cross and Blue Shield of TX may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. Blue Cross and Blue Shield of TX has full and final discretionary authority for their interpretation and application to the extent provided under any applicable plan documents.

Providers are responsible for submission of accurate documentation of services performed. Providers are expected to submit claims for services rendered using valid code combinations from Health Insurance Portability and Accountability Act approved code sets. Claims should be coded appropriately according to industry standard coding guidelines including, but not limited to: Uniform Billing Editor, American Medical Association, Current Procedural Terminology® Assistant, Healthcare Common Procedure Coding System, ICD-10 CM and PCS, National Drug Codes, Diagnosis Related Group guidelines, Centers for Medicare and Medicaid Services National Correct Coding Initiative Policy Manual, CCI table edits and other CMS guidelines.

Claims are subject to the code edit protocols for services/procedures billed. Claim submissions are subject to claim review including but not limited to, any terms of benefit coverage, provider contract language, medical policies, clinical payment and coding policies as well as coding software logic. Upon request, the provider is urged to submit any additional documentation.

Anesthesia Information

Policy Number: CPCP010

Version: 2.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: February 22, 2024

Plan Effective Date: August 14, 2024 (Blue Cross and Blue Shield of Texas Only)

Description:

This policy was created to serve as a general reference guide for anesthesia services. It is the provider’s responsibility to ensure the codes 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 policy may be made at any time. Any updates will result in an updated publication of this policy.

Services involving anesthesia administration should be using Current Procedural Terminology anesthesia five-digit procedure codes, or CPT surgical codes plus an appropriate modifier. Providers should determine the most appropriate CPT code(s) for surgical procedures and crosswalk the CPT code(s) to the appropriate anesthesia procedure-code combination.

When a single code exists that describes the services being rendered, the provider must report the single code and should not submit multiple codes.

An anesthesiologist or a qualified nonphysician anesthetist service (Certified Registered Nurse Anesthetist or an Anesthesiologist Assistant, can provide anesthesia services 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 Book, services involving administration of anesthesia include the usual pre-operative and post-operative visits, the anesthesia care during the procedure, the administration of fluids and/or blood, the usual physiological monitoring services (e.g., ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry), and other supportive services. 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.

There are a number of factors utilized to determine 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. The time reported is the combined total for all procedures.

NOTE: Not all anesthesia procedure codes are paid based on time and points methodology. Claims are subject to the code edit 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 required modifiers for the first modifier position, when applicable.

	Modifier	Description	When to Append a Modifier
Modifier Information Billed by an Anesthesiologist MD	AA	Anesthesia services performed personally by the anesthesiologist	Append modifier when performed only by the Anesthesiologist.
	AD	Medical supervision by a physician, more than four concurrent anesthesia procedures	Append modifier when service was supervised by an Anesthesiologist.
	QK	Medical Direction of two, three or four concurrent anesthesia procedures involving qualified individuals	Append modifier when these concurrent procedures are under the direction of the Anesthesiologist.
	QY	Medical Direction of one certified registered nurse by an anesthesiologist	Append modifier when one CRNA or AA is under the direction of the Anesthesiologist.
	Modifier	**Description**	**When to Append a Modifier**
Modifier Information Billed by a CRNA and/or AA	QX	CRNA service with medical direction by a physician	Append modifier when CRNA or AA provides service under medical direction from a physician.
	QZ	CRNA service: without medical direction by a physician	Append modifier when CRNA provides service without medical direction by a physician.

The following modifiers should be billed in the second modifier position.

Modifiers	Description
QS	Monitored anesthesia care service
G8	Monitored anesthesia care for deep complex, complicated, or markedly invasive surgical procedure
G9	Monitored anesthesia care for a patient who has a history of severe cardiopulmonary condition
GC	This service has been performed in part by a resident under the direction of a teaching physician
GE	This service has been performed by a resident without the presence of a teaching physician under the primary care exception

Modifiers	Description
GF	Nonphysician (e.g., nurse practitioner, certified registered nurse anesthetist, certified registered nurse, clinical nurse specialist, physician assistant services in a critical access hospital
22	Increased Procedural Services (applied for field avoidance only – see below for additional information)
23	Unusual Anesthesia
47	Anesthesia by Surgeon (Anesthesiologist not covered with this modifier)

Physical Status Modifiers

The American Society of Anesthesiologists 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.

Physical Status Modifier	Description/Status Classification
P1	A normal healthy person (ASA I)
P2	A patient with mild systemic disease (ASA II)
P3	A patient with severe systemic disease (ASA III)
P4	A patient with severe systemic disease that is a constant threat to life (ASA IV)
P5	A moribund patient who is not expected to survive without the operation (ASA V)
P6	A declared brain-dead patient whose organs are being removed for donor purposes (ASA VI)

NOTE: Physical status modifiers are not utilized to determine payment for anesthesia services.

Anesthesia Time Units and Base Points & Qualifying Circumstances

For in-network professional providers, (time units + base unit value and/or qualifying circumstances listed below (if applicable) equals total units. Allowable amount equals the anesthesia conversion factor multiplied by the total units.

Total units allowed = (Time Units + Base Units Value) x Conversion Factor

The following anesthesia services are included in the base unit value and are not eligible for separate reimbursement:

- Preoperative and postoperative visits
- The administration of fluids and/or blood products incident to the anesthesia care (including venipuncture and/or introduction of needle or catheter)
- Laryngoscopy and/or bronchoscopy
- Retrobulbar injection
- Cardiopulmonary resuscitation, cardioversion, temporary pacemaker, or inhalation treatments.

Time Units

Time units are based on 15-minute increments

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. 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. Allowed from Qualifying Circumstances = Qualifying Circumstance Value x Conversion Factor.

Qualifying Circumstances to be billed by anesthesiologists and/or CRNAs	**CPT**	**Description**	**Unit Value(s)**
	99100	ANESTHESIA	1
	99116	ANESTHESIA, LOW BODY TEMP	5
	99135	ANESTHESIA, LOW BLOOD PRESSURE	5
	99140	ANESTHESIA IN EMERGENCY	2

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.
- Routine postoperative evaluation is included in the base unit for the anesthesia service rendered. Postoperative E/M services that are related to the member's surgery are not separately reportable by the Anesthesiologist except when an Anesthesiologist provides significant, separately identifiable ongoing critical care services.
- 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 services (CPT 90870).
- Modifier 22 may be used when access to the airway is limited (e.g., field avoidance), and the anesthesia work required is substantially greater compared to the typical patient. There is no modifier that identifies field avoidance. Documentation must support the substantial additional work and the reason for the additional work. Additional payment secondary to field avoidance is subject to the following:
    - The documentation must be included in the member's anesthesia record.
    - The base unit is less than 5 units, *and*
    - The procedure is performed around the head, neck, or shoulder girdle, and/or
    - The position requires a position other than supine.

Daily Hospital Management of Epidural or Subarachnoid Continuous Drug Administration

CPT code 01996, daily hospital management, is for continuous epidural or subarachnoid drug administration that is performed after the insertion of an epidural or subarachnoid catheter. This code is included in the initial procedure when submitted on the same date of service by the same qualified health care provider. Only base units will be allowed each day, time or service units are not used to determine the reimbursement.

Routine Services, Supplies and Equipment

Routine services, supplies and equipment are those necessary and integral to the delivery of anesthesia in the surgical setting and are not separately reimbursable. In addition, all re-usable and disposable equipment used in the delivery of anesthesia and surgical services are not additionally reimbursable as they are integral to the anesthesia service charges.

Multiple Anesthesia Services on the Same Day

For multiple surgical procedures that are performed during a single anesthesia administration, providers should report only the single anesthesia code for anesthesia service for the highest Base Unit Value, plus the time for all anesthesia services combined. Time reported equals the combined total for all procedures that are performed on the same member on the same date of service by the same or different physician or other qualified health care professional. If a claim is submitted that includes multiple general anesthesia service codes (00100-01999), the highest submitted charge will be eligible for reimbursement and the secondary anesthesia services will be denied. Exceptions to this are add-on anesthesia codes, such as, 01953, 01968 and 01969.

Duplicate Anesthesia Services on the Same Day

If duplicate anesthesia codes are reported by the same or different physician or other qualified health care professional for the same patient on the same date of service, the Plan will only reimburse the first submission of that code. However, the anesthesia administration services can be provided simultaneously by a physician and a CRNA during the same operative session and must be reported with appropriate modifiers identified above.

Tumescent Anesthesia

Tumescent anesthesia is included in endovenous ablations and is not separately reimbursable.

References:

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ASA Physical Status Classification System
https://www.asahq.org/standards-and-guidelines/asa-physical-status-classification-system

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Centers for Medicare & Medicaid Services (CMS) 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
04/03/2020	Annual Review, Disclaimer Update
09/13/2021	Annual Review
09/02/2022	Annual Review
03/14/2023	Ad-hoc review
02/09/2024	Annual Review
02/22/2024	Ad-hoc