PROFESSIONAL NETWORK REIMBURSEMENT POLICY

POLICY TITLE	Anesthesia and Pain Management Services
POLICY NUMBER	NR- 10.005

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DESCRIPTION/BACKGROUND DEFINITIONS POLICY
EXCLUSIONS-Yes VARIATIONS-Yes REFERENCES

I. DESCRIPTION/BACKGROUND TOP

This policy documents the reporting requirements and reimbursement methodology for anesthesia services.

II. DEFINITIONS TOP

Analgesic – A drug that relieves pain. The opioid analgesics act on the central nervous system and alter the patient's perception; they are usually used for severe pain. Nonopioid analgesics act primarily on the periphery, do not produce dependence, and do not alter the patient's perception. Nonopioid analgesics are usually prescribed for mild to moderate pain.

Anesthesiologist – A physician who has completed an accredited residency in anesthesia. An anesthesiologist can administer anesthesia directly, supervise nurse anesthetists in the delivery of anesthesia, and act as consultants.

Anesthesiology – The practice of medicine dealing with, but not limited to, the management of procedures for rendering a patient insensible to pain and emotional stress during surgical, obstetrical and certain medical procedures. Anesthesia care may include, but is not limited to, general, regional, monitored anesthesia care, supplementation of local anesthesia, or other supportive services in order to afford the most beneficial care for the patient.

Catheter – A hollow, flexible tube that can be inserted into a vessel or cavity of the body to withdraw or to instill fluids, directly monitor various types of information, and visualize a vessel or cavity. Most catheters are made of soft plastic, rubber, or silicon.

Certified Registered Nurse Anesthetist – CRNA; A registered nurse who has attended an accredited nurse anesthesia education program to receive an extensive education in anesthesia. Upon completion of the program, the nurse must pass a national certification exam to become a CRNA.

CPT – The physician's Current Procedural Terminology coding system is a national standard numeric procedure coding system established by the American Medical Association to standardize provider billing and payment.

General anesthesia – A means of causing the loss of the ability to perceive pain due to the loss of consciousness produced by the infusion of medications or inhalation of anesthetic agents.

HCPCS – The Healthcare Common Procedure Coding System is a national standard alphanumeric coding system established by the Centers for Medicare and Medicaid Services. It standardizes billing and payment for certain covered services (for example, medical supplies, prosthetics and durable medical equipment). HCPCS Level I codes are copyrighted by the American Medical Association (AMA). Level II codes are five-position alphanumeric codes maintained jointly by the Alpha-Numeric Panel (consisting of the Centers for Medicare and Medicaid Services (CMS), the Health Insurance Association of America, and the Blue Cross and BlueShield Association). The American Dental Association copyrights the D-code series in Level II HCPCS.

Infusion Pump – An apparatus designed to deliver measured amounts of drug or IV solution through IV injection over time. Some kinds of infusion pumps can be implanted surgically.

Intravenous patient-controlled anesthesia (IV-PCA) – Self-administered, low doses of intravenous narcotic medication via a pump for the relief of pain.

Local anesthesia – The loss of the ability to perceive pain in a small area of the skin, using topical application of an anesthetic agent onto the skin or mucous membranes, or into an incision, wound, catheter or lesion.

Moderate Conscious Sedation - Moderate (conscious) sedation is a type of anesthesia that achieves and sustains a medically controlled state of depressed consciousness while maintaining the patient's airway and reflexes. It allows the patient to respond to stimulation or verbal commands and includes the

performance and documentation of pre- and postsurgical evaluations, administration of anesthesia, and patient monitoring.

Modifier – A two-digit numeric, alphanumeric or alphabetic code appended to a CPT or HCPCS code, which indicates that a service or procedure has been altered by some specific circumstances but not changed in its definition or code. This information is important because it provides payors with additional information to process a claim. There are three levels of modifiers: Level I (CPT) modifiers are developed by the American Medical Association; Level II (HCPCS) modifiers are developed by the Centers for Medicare and Medicaid Services; Level III modifiers are unique to each Medicare Part B carrier and begin with an alpha prefix of S, W, X, Y or Z.

Patient-controlled epidural analgesia – An epidural or catheter is inserted, and an anesthetic agent or narcotic is used in conjunction with a pump to deliver small doses of the agent directly to the spinal nerves.

Percutaneous – That which is passed through the skin (e.g., biopsy, aspiration of fluid from a space below the skin using a needle, instillation of a fluid in a cavity or space).

Regional anesthesia – The loss of the ability to perceive pain involving the use of local anesthesia agent(s) to produce circumscribed areas of loss of sensation, such as nerve block, spinal, epidural and field block.

III. POLICY

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Capital Blue Cross utilizes the Optum™ Claims Edit System (CES) as the primary software resource for the validation of correct coding and the application of reimbursement methodology for anesthesia services. In general, the CES software is based on guidelines published by, but not limited to:

- the American Society of Anesthesiologists (ASA)
- the American Medical Association (AMA)
- the Centers for Medicare and Medicaid Services (CMS)

Claims submitted for the administration of anesthesia must include the applicable anesthesia HCPCS code and modifier(s), anesthesia time (including the start and stop times) and when applicable, qualifying circumstance procedure codes and/or physical status modifiers.

Calculation of the Plan allowance for eligible anesthesia services is determined utilizing the following formula:

Time units will be determined by using the total time in minutes actually spent performing the procedure. Fifteen minutes is equivalent to one (1) time unit. Time units will be rounded to the tenth. Therefore, if the procedure lasted 20 minutes, the time units in this example would be 20/15 =1.3 time units.

Anesthesia time, should be reported beginning when the anesthesiologist initiates preparation of the patient for anesthesia administration and ends when the patient no longer requires the anesthesiologist (the patient may be safely placed in post-anesthesia recovery under the supervision of nursing or other trained personnel), must also be submitted with all anesthesia claims. Anesthesia time units must be reported in total minutes and will be converted into fifteen (15) minute increments, with the exception of certain obstetrical anesthesia procedure codes as documented later in this policy.

Base units, in general, the CES utilizes the base units assigned by the ASA when identifying the appropriate units assigned for the calculation of reimbursement for anesthesia services.

Additional reimbursement methodologies and modifiers that may impact reimbursement of anesthesia services include, but are not necessarily limited to the following:

Multiple Surgical Procedures

When multiple surgical procedures are performed during a single anesthetic administration, only the anesthesia code with the highest base unit value is eligible for reimbursement consideration. The allowance for all procedure codes with lower base units is included in the allowance for the procedure code with the highest base unit.

Integral Services

The following services are generally considered to be integral parts of an anesthesia service, and *should not* be reported separately. These services are not eligible for separate reimbursement consideration:

- Pre-anesthesia evaluation
- Post-operative visits and post-obstetric delivery pain management
- Anesthetic or analgesic administration
- All necessary monitoring, including EKGs and invasive monitoring by catheter
- Administration of drugs, IV fluids and blood
- Services administered in the recovery room

Invasive Monitoring
Interpretation of the data obtained from invasive monitoring devices is accounted for in the usual anesthesia fee. Placement or insertion of the invasive monitor, however, is not.

Additional Medical/Surgical Services
The following services may be eligible for separate reimbursement consideration when provided in addition to the anesthesia service when National Correct Coding Initiative (NCCI) guidelines do not preclude separate payment. These services may be furnished in conjunction with the anesthesia procedure, or may be furnished as a single service during the day of the surgery or the day before surgery. Payment for these procedures will be made according to Plan allowance. Time is not a consideration in reimbursing these procedures and should not be reported:

- Pulmonary artery (Swan-Ganz) catheter insertion
- Central venous pressure (CVP) line insertion
- Intra-arterial lines
- Emergency intubation
- Critical care visits
- Transesophageal echocardiography

Aborted/Discontinued Anesthesia Services- Modifier 53: Discontinued procedure
In the event a surgical or diagnostic procedure is cancelled *prior to the induction* of anesthesia due to the **anesthesiologist's preoperative appraisal**, the provider must report an evaluation and management visit or consultation procedure code, based on the level of care provided. Reimbursement will be made based on the Plan allowance for the evaluation and management service.

Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure *after the induction of anesthesia* as a result of extenuating

circumstances or because continuation of the procedure poses a potential threat the patient's well-being. Under the aforementioned circumstances, the anesthesiologist should report **procedure code 01999 appended with modifier 53, along with time units and a description of the service performed**. Payment will be made on the basis of 3 anesthesia units plus time units multiplied by the conversion factor.

Stand-By Anesthesia
Stand-by anesthesia is distinguished from anesthesia service, when the anesthesiologist makes himself/herself available in the event his/her specific skills are necessary. Stand-by anesthesia is not eligible for separate reimbursement consideration, even if required by the facility in which the surgery takes place.

Unusual Circumstances-Modifiers 23
In certain unusual circumstances (such as a complicated trauma case), a procedure that would normally require either no anesthesia or local anesthesia must be performed under general anesthesia. In such situations, the anesthesiologist is involved completely and fully with a single case. The claim should be submitted using **Modifier 23**, with the appropriate anesthesia procedure code and supporting documentation. Payment will be made at 5% over the Plan allowance.

Services performed by both Anesthesiologist and a CRNA- Modifier AA: Anesthesia services performed personally by the anesthesiologist and Modifier QZ: CRNA service without medical direction by a physician.

Certain scenarios can require the full and complete services of both an anesthesiologist *and* a CRNA. Payment may be made at the Plan allowance to each provider if the appropriate modifier(s) are appended to the procedure code. Claims should be submitted using the **Modifier AA** for the anesthesiologist, and the **Modifier QZ** for the CRNA. These scenarios include, but are not limited to, ruptured aneurysms, pediatric and neonatal congenital heart surgery, organ transplantation and surgery for major body burns. Other situations may be reviewed and given individual consideration.

Pain Management Services
Pain management services are not anesthesia services. These are distinct services frequently performed by anesthesiologists who have additional training in pain management procedures. The following are examples of pain management techniques:

- Patient Controlled Analgesia (PCA) – This is a technique that involves self-administration of IV drugs through an infusion device. When PCA is

initiated in the recovery room by an anesthesiologist as part of the anesthesia time, the initial set-up time for PCA can be incorporated into the total number of anesthesia time units reported. Any PCA service performed after the anesthesia care is ended, including initial set-up, subsequent adjustments, or follow up related to this therapy, is considered routine post-operative pain management, regardless of who performs it, and is not separately payable. Also, when PCA is administered for non-surgical pain management, it is considered to be an integral part of a physician's medical care, and is not eligible for payment as a separate service.

- Epidural Analgesia – This technique involves the administration of a narcotic drug through an epidural catheter. Insertion of an epidural catheter and injection of an anesthesia should be reported as procedure 62326. Daily management of the epidural drug administration (01996) is eligible after the day on which the catheter was inserted. Payment will be made at Plan allowance determined by the Plan anesthesia formula. Payment is not allowed for both the insertion of the catheter and the daily management of the drug on the same day. An epidural injection administered, as a therapeutic agent in the treatment of non-surgical pain should be reported under code 62322 or 62326. Any follow up care will be paid based on the level of medical care reported.
- Nerve Block – When an injection/block is administered post-operatively by an anesthesiologist in the recovery room as part of the anesthesia time, any additional time required for the injection may be included in the total number of anesthesia minutes reported. Payment will be made at full Plan allowance determined by the Plan anesthesia formula. Any subsequent adjustments or injections concerning this treatment are considered routine postoperative pain management, regardless of who performs it, and are not eligible for separate payment. Injections/blocks administered as a therapeutic agent in the treatment of a non-surgical condition should be reported under the appropriate injection/block code, and payment will be paid based on the Plan allowance in effect at the time of the service for that CPT code.
- Trigger Point Injections – A trigger point injection is a technique used for management of chronic pain. The injection is achieved with needle insertion and administration of medication such as local anesthetics, steroids or local inflammatory drugs. When a given site is injected, it is considered to be one injection service, regardless of the number of injections administered. More than one body region may be injected on a given date (use CPT code 20552 or 20553, as appropriate). Anesthesiologists billing for a trigger point injection(s) should receive

payment for the surgical procedure (CPT code 20552 or 20553 as appropriate).

- Elastometric Infusion Pumps - When performed by the surgeon, post-surgical pain management is considered a part of the Plan allowance for the global surgery package. Reimbursement for catheter insertion and removal to provide continuous delivery of a drug to a surgical site is included in the allowance for the surgery and not eligible for separate reimbursement. When performed by the anesthesiologist, post-operative analgesic administration is considered to be integral to an anesthesia service and is not eligible for separate reimbursement. The elastometric infusion pump is a supply, generally reported as a facility expense, and is not eligible for separate reimbursement.

Moderate (Conscious) Sedation

This service is eligible for reimbursement consideration at the Plan allowance for the appropriate CPT codes.

Obstetrical Anesthesia

Reimbursement for the administration of anesthesia related to a vaginal or cesarean section delivery will be made at the Plan allowance, determined by the Plan anesthesia formula, limited to 10 (ten) hourly time units. In addition, reimbursement of neuraxial labor analgesia/anesthesia for planned vaginal delivery is limited to 3 (three) units of patient contact time. Post-obstetrical pain management services, such as adjustment of catheter placement and re-injections are not eligible for separate reimbursement consideration.

Monitored Anesthesia Care

Monitored anesthesia care (MAC) involves the intra-operative monitoring 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.

Adequate medical and pharmacological equipment must be readily available at all times during MAC. Qualified anesthesia personnel must provide MAC, and these individuals must be continuously present to monitor the patient and provide anesthesia care. Appropriate documentation must be available to reflect the pre- and post-anesthetic evaluations and intra-operative monitoring. Reimbursement for MAC will be the same amount allowed for general or regional anesthesia services. When reporting MAC, always append **modifier QS** in the second position.

- **Modifier QS: Monitored anesthesia care service**

Anesthesia Services for Harvesting Organs and Tissue from a Cadaver
Reimbursement for anesthesia associated with an eligible organ or tissue transplant is limited to the base and time units only. Additional reimbursement will not be considered for physical status modifiers or qualifying circumstance procedure codes.

Anesthesia Services Personally Performed by the Physician (Anesthesiologist)
The physician should report the service as performed "by me personally" when

- The anesthesiologist personally provides the entire anesthesia service, and
- The anesthesiologist and an anesthetist are both completely and fully involved in a single anesthesia service.

Modifier AA should be appended to the procedure code reported by the anesthesiologist. Any circumstances other than those listed above are considered to be *medical direction* and should be reported as such.

Payment may be made to an instructor who is an anesthesiologist and who is continuously present when a student nurse anesthetist provides a medical or surgical service.

Additionally, payment may be made at Plan allowance to a teaching CRNA who supervises a single case involving a student nurse anesthetist where the CRNA is continuously present. In this instance, the CRNA reports the service using **modifier QZ**. This indicates that an anesthesiologist does not medically direct the teaching CRNA. Services provided by the student nurse anesthetist are not eligible for reimbursement.

When an independent CRNA (not employed by the anesthesiologist or hospital) provides unsupervised anesthesia services, payment should be made according to the Plan allowance.
Modifier QZ should be reported.

- **Modifier AA: Anesthesia services performed personally by the anesthesiologist.**
- **Modifier QZ: CRNA service without medical direction by a physician**

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Medical Direction (Supervision) of Anesthesia

Medical direction or supervision of anesthesia is defined as anesthesia direction, management, or instruction by one who is physically present or immediately available in the operating suite. An anesthesiologist having this obligation should not actually be administering anesthesia. Reimbursement is limited to the medical direction of no more than four anesthesia services being performed concurrently.

Reimbursement for the medical direction of eligible anesthesia services is made as follows:

For Residents (physician-in-training):

- When an anesthesiologist medically directs a physician-in-training (intern or resident), payment should be made in the same manner as for the anesthesiologist's personal performance of the service (Plan allowance). The physician should report the anesthesia procedure code followed by **modifier GC**.
  - **Modifier GC: This service has been performed in part by a resident under the direction of a teaching physician**

For CRNA Employed by the Anesthesiologist:

- When an anesthesiologist medically directs a CRNA who is employed by the anesthesiologist, payment should be made in the same manner as for the anesthesiologist's personal performance of the service (100% of the Plan allowance). The CRNA's services are not eligible for separate reimbursement if the anesthesiologist reports the same service rendered to the same patient, without appending the appropriate modifier. If reporting the services of both the anesthesiologist and the CRNA, the anesthesiologist should report the service with **modifier QK or QY** and the CRNA should report the services with **modifier QX**. Both the anesthesiologist and the CRNA will receive 50% of the Plan allowance for the services performed.
  - **Modifier QK: Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals**
  - **Modifier QX: CRNA service with medical direction by a physician**

- **Modifier QY: Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist**

Hospital-Employed CRNA:

- When an anesthesiologist medically directs a CRNA not employed by the anesthesiologist (but employed by the hospital), the anesthesiologist's payment is 50% of the Plan allowance. The remaining 50% is an integral part of the facility payment for the anesthesia services. The anesthesiologist should report the service with m**odifier QK or QY**.

Independent CRNA:

- When an anesthesiologist medically directs an independent CRNA (not employed by anesthesiologist or hospital), the anesthesiologist's payment is 50% of the Plan allowance for personally administering the anesthesia. The CRNA will be paid the remaining 50%. The anesthesiologist should report the service with **modifier QK or QY** and the CRNA should report the service with **modifier QX**
- Independent CRNAs who perform services without medical direction by an anesthesiologist or another qualified health care provider such as a physician (MD or DO) or an oral surgeon (DMD), should report the service with **modifier QZ**. Payment will be made at 100% of the Plan allowance.
  - **Modifier QZ: CRNA service without medical direction by a physician**

When an anesthesiologist supervises or directs the provision of anesthesia services to more than four patients simultaneously, supervisory services are reimbursed at the Plan allowance of three base units per procedure only. Additional time units are not considered for reimbursement. The anesthesiologist's services are considered supervisory in nature and will be reimbursed at 3 base units + 0 time units (at 100% of the Plan allowance).

Modifier AD should be reported for this scenario.

- **Modifier AD: Medical supervision by a physician, more than four concurrent anesthesia procedures**

In order to be considered for reimbursement, documentation must exist to substantiate the use of **Modifier AD**.

In addition to the criteria and conditions contained in this policy, the service, procedure or item must be deemed medically necessary, must be a covered member benefit and is subject to member cost sharing provisions.

IV. EXCLUSIONS

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Local anesthesia is not eligible for separate reimbursement consideration. Anesthesia administered by the operating surgeon is considered integral to the surgical procedure and is not eligible for separate reimbursement consideration except as documented in NR 10.012 "Dental Procedures and Related Anesthesia Services".

V. VARIATIONS

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This policy is applicable to all programs and products administered by Capital Blue Cross unless otherwise indicated below.

Medicare Advantage PPO[1,2] Medicare Advantage HMO[1,2]

[1]Reimbursement of anesthesia services for the Medicare Advantage HMO and Medicare Advantage PPO products does not include additional reimbursement for physical status modifiers.

[2]Additional reimbursement for anesthesia qualifying circumstances (modifying units) is not allowed. When these procedure codes (99100, 99116, 99140 and 99135) are submitted, payment will be denied.

This policy is applicable to all programs and products administered by Capital Blue Cross unless otherwise indicated below.

VI. REFERENCES

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CPT 2021Professional Edition
American Medical Association

EncoderPro for Payers
Optum™ 2021

HCPCS Level II Expert
Optum™ 2021

Additional information from the American Society of Anesthesiologists (ASA) can be located by accessing the ASA website

Additional information from the Centers for Medicare and Medicaid Services (CMS) can be located by accessing the CMS website