BlueCross BlueShield of Illinois

If a conflict arises between a Clinical Payment and Coding Policy ("CPCP") 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. BCBSIL may use reasonable discretion interpreting and applying this policy to services being delivered in a particular case. BCBSIL 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 ("HIPAA") 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"), ICD-10 CM and PCS, National Drug Codes ("NDC"), Diagnosis Related Group ("DRG") guidelines, Centers for Medicare and Medicaid Services ("CMS") National Correct Coding Initiative ("NCCI") 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 Clinical Payment and Coding Information

Policy Number: CPCP010

Version: 3.0

Enterprise Clinical Payment and Coding Policy Committee Approval Date: Sept. 13, 2021

Plan Effective Date: Sept. 13, 2021

Description:

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.

This policy applies to in-network and out-of-network physicians and other qualified health care professionals.

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. 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.

An anesthesiologist or a Certified Registered Nurse Anesthetist (CRNA)/Anesthesia Assistant (AA) can provide anesthesia services. When an anesthesiologist provides medical direction to the CRNA/AA, both the anesthesiologist and the CRNA/AA 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.

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. 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 pricing modifiers that are required to be billed in the first modifier position.

Modifier Information Billed by an Anesthesiologist MD	Modifier	Description	When to Append a Modifier
	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 (CRNA) by an anesthesiologist	Append modifier when one CRNA or AA is under the direction of the Anesthesiologist.
Modifier Information Billed by a CRNA/AA	**Modifier**	**Description**	**When to Append a Modifier**
	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 or AA provides service without medical direction by a physician.

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

For additional information on status classification, refer to the ASA Physical Status Classification System via this link: https://www.asahq.org/standards-and-guidelines/asa-physical-status-classification-system

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 (Anesthesiologist not covered with this modifier)

Anesthesia Time Units and Base Points

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

Allowed from Time and Points = (Time Units + Base Units + Unit Value (s)) x Conversion Factor

Time Units

Time units are based on 12-minute increments

For out-of-network providers, the Plan follows industry standard guidelines and member's benefit coverage.

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. 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	SPECIAL ANESTHESIA SERVICE	1
	99116	ANESTHESIA WITH HYPOTHERMIA	5
	99135	SPECIAL ANESTHESIA PROCEDURE	5
	99140	EMERGENCY ANESTHESIA	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.
- 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).

Routine Services, Supplies and Equipment

Routine services, supplies and equipment are those necessary and integral to the delivery of anesthesia in the surgical setting an 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.

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