ANESTHESIA, PROFESSIONAL AND FACILITY

File Name: anesthesia_MA
Origination: 6/2022
Last Review: 12/2022
Next Review: 12/2023

Description

Anesthesia services include all services typically associated with the administration and monitoring of analgesia or anesthesia in order to produce partial or complete loss of sensation and/or consciousness. For purposes of this reimbursement policy, anesthesia services include general anesthesia, regional anesthesia, and monitored anesthesia care (MAC).

Current Procedural Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) codes and modifiers provide necessary detail to services rendered. Blue Cross NC follows the instruction and guidance of code and claim form issuers, including but not limited to CPT®, HCPCS, UB-04, and ICD-10.

In accordance with the North Carolina Medical Board Position Statement entitled Office Based Procedures, *"Anesthesia should be administered by an anesthesiologist or a CRNA supervised by a physician. The physician who performs the surgical or special procedure should not administer the anesthesia. The anesthesia provider should not be otherwise involved in the surgical or special procedure."*

Blue Cross Blue Shield North Carolina (Blue Cross NC) uses several factors in determining reimbursement for anesthesia care, including but not limited to: base units, time units, conversion factors, and modifiers.

Policy

Blue Cross NC will reimburse anesthesia services according to the criteria outlined in this policy.

Reimbursement Guidelines

Blue Cross NC maintains reimbursement guidelines for anesthesia services consistent with guidance found in Chapter 12 of the CMS Claims Processing Manual. Anesthesia services may be charged individually as used or included in a charge, based on time. A charge that is based on time must be computed from the induction of anesthesia until surgery is complete. This charge includes the use of equipment (e.g., monitors), all supplies and all gases. Anesthesia units should be reported one (1) unit equals a one-minute (1-minute) increment. Do not include base units of the procedure with the time units.

Anesthesia Modifiers

All anesthesia services are reported by use of the anesthesia five (5) digit procedure code plus the addition of a modifier(s). Modifiers are added to modify or give additional definition to the service performed, and in certain circumstances add additional units to the base unit values. The anesthesia modifier must be submitted in the first position after the procedure code, before other non-anesthesia modifiers. Surgical codes are not to be reported with anesthesia modifiers. Every timed service must have a modifier. Finally, anesthesia services are required to be appended with the appropriate modifier signifying who performed the anesthesia services.

However, it is not appropriate to bill multiple anesthesia modifiers on the same claim line as they are considered mutually exclusive.

Anesthesia Modifiers	
AA	Anesthesia services performed personally by anesthesiologist
AD	Medical supervision by a physician: more than 4 concurrent anesthesia procedures
AD	Direction of residents in furnishing not more than 2 concurrent anesthesia procedures
QK	Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals
QS	Monitored anesthesiology care services (can be billed by a qualified nonphysician anesthetist or a physician)
QX	Qualified nonphysician anesthetist with medical direction by a physician
QY	Medical direction of one qualified nonphysician anesthetist by an anesthesiologist
QZ	CRNA service: without medical direction by a physician

Multiple General Anesthesia Services

When multiple general anesthesia services are performed on the same date of service, only the procedure with the highest base value should be reported, in addition to the time for all anesthesia services combined. Since only one anesthesia code should be reported per date of service, any additional anesthesia codes will not be eligible for reimbursement when a different code from the same range has been previously paid for the same date of service

Daily Hospital Management

Daily hospital management of epidural or subarachnoid continuous drug administration should not be reported with anesthesia qualifying circumstance codes or physical status modifiers. Anesthesia qualifying circumstance codes should always be reported with the appropriate primary anesthesia procedure codes.

Anesthesia for Pain Management Injections

Under most routine circumstances, minor pain management procedures, including but not limited to, epidural steroid injections, trigger point injections, and epidural blood patch, only require local anesthesia. For adults, an accompanying surgical procedure (other than a pain management procedure) must also be present on the claim for the associated anesthesia and moderate sedation service to be eligible for reimbursement.

Anesthesia Supplies

Regardless of place of service, Blue Cross NC considers anesthesia supplies incidental to the anesthesia service codes (00100 – 01999) and will not be eligible for separate reimbursement.

Rationale

Anesthesia services as defined in this policy will be reimbursed consistent with guidance from CMS, expert medical society standards as set forth herein and in accordance with correct coding guidelines.

Billing and Coding

Applicable codes are for reference only and are **not** all inclusive. For further information on reimbursement guidelines, please see the Blue Cross NC web site at www.bcbsnc.com.

Related policy

Bundling Guidelines

Modifier Guidelines

Pricing & Adjudication Principles

References

American Society of Anesthesiologists (ASA) and ASA Relative Value Guide

Healthcare Common Procedure Coding System

American Medical Association, *Current Procedural Terminology* (CPT®)

Centers for Medicare & Medicaid Services, CMS Manual System, Medicare Claims Processing Manual 100-04, OPPS, and OCE

History

6/1/2022	New policy developed. Medical Director approved. **Notification on 3/31/2022 for effective date 6/1/2022**. (eel)
8/1/2022	"Anesthesia Supplies" added to Reimbursement Guidelines section. **Notification on 6/1/22 for effective date 8/1/2022.** (cjw)
12/31/2022	Routine Policy Review. Minor revisions only. (cjw)

Application

These reimbursement requirements apply to all Blue Medicare HMO, Blue Medicare PPO, Blue Medicare Rx members, and members of any third-party Medicare plans supported by Blue Cross NC through administrative or operational services.

This policy relates only to the services or supplies described herein. Please refer to the Member's Evidence of Coverage (EOC) for availability of benefits. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this policy.

Legal

Reimbursement policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the group contract and subscriber certificate that is in effect at the time services are rendered. This document is solely provided for informational purposes only and is based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. Medical practices and knowledge are constantly changing and Blue Cross NC reserves the right to review and revise its medical and reimbursement policies periodically.