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Anesthesia Policy - Commercial

Values

Accountability ● Integrity ● Service Excellence ● Innovation ● Collaboration

Abstract Purpose:

This reimbursement policy outlines Network Health's process, for the Commercial line of business, when professional claims are submitted for anesthesia services.

Policy Detail:

Anesthesia should always be provided by a physician or a nurse with specialty training, or by a specially trained anesthesia assistant. Network Health's reimbursement guideline for anesthesia services is developed in part to identify services rendered using the Centers for Medicare and Medicaid Services (CMS), the Amercian Society of Anesthesiologists (ASA) Relative Value Guide (RVG) guidelines, the ASA Crosswalk Guide, Current Procedural Terminology (CPT) codes and modifiers, along with Healthcare Common Procedure Coding System (HCPCS) modifiers.

I. Anesthesia is defined by the following four categories:

A. **Local**: Infiltration of anesthetic agents to a limited area, used for minor procedures such as biopsies, and the excision of skin tumors and lesions.

B. **General**: Total loss of consciousness and reflexes due to the administration of drugs and inhalation agents.

C. **Monitored Anesthesia Care**: Induced by the administration of intravenous drugs, conscious sedation may vary from minimal to significant awareness with retention of protective reflexes.

D. **Regional**: Use of anesthetic agents with or without sedation to provide pain relief or loss of sensation to a specific area of the body such as epidural anesthesia or a brachial plexus block.

II. **Reimbursement**:

A. Anesthesia services should be reported using the standard ASA or CPT code.

B. All eligible ASA codes will be reimbursed with the following formula:
   1. Base + time equals total units, multiplied by specified rate outlined in

provider contract.

2. All ASA Base only codes will be reimbursed at one hundred percent (100%) of the current year, Medicare Part B Facility/Non-Facility Fee Schedule.
3. All allowable CPT codes without an ASA crosswalk or anesthesia Base unit will reimburse at the default rate specified in the provider contract.

III. **Local Anesthetics**:

A. When HCPC code J3490 (Unclassified drugs) or J3590 (Unclassified biologics) are submitted for Lidocaine, Marcaine or Bupivacaine, in an office setting (Place of Service 11), or an On Campus-Outpatient Hospital setting (Place of Service 22), the charges are considered bundled to the primary procedure.

B. The charges will deny provider liability with Claim Adjustment Reason Code (CARC) Code 97 "*The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."*

IV. **Modifier Submission**:

A. In alignment with CMS, physicians must append the appropriate anesthesia modifier to denote whether the service was personally performed, medically directed or medically supervised. Reimbursement for the service is determined by the use of the appropriate modifiers.

B. If the claim is submitted without one of the required modifiers listed below, it will be denied with Claim Adjustment Reason Code (CARC) 4/"*The procedure code is inconsistent with the modifier used".*

1. Anesthesia code 01996 is excluded from this requirement.
2. Reimbursement will be fifty percent (50%) of the allowed amount when anesthesia services are submitted with Modifier(s) QK, QX **or** QY.
3. The required modifiers include:

C. **Modifier AA** – Anesthesia services performed personally by Anesthesiologist.

D. **Modifier AD** – Medical supervision by a physician; more than four concurrent anesthesia procedures.

E. **Modifier QK** - Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals.

F. **Modifier QX** - Certified Registered Nursing Anesthetist (CRNA) service with medical direction by a physician.

G. **Modifier QY** - Medical direction of one Certified Registered Nurse Anesthetist (CRNA) by an anesthesiologist.

H. **Modifier QZ** – CRNA Service: Without medical direction by a Physician.

I. For informational purposes and only in addition to the required anesthesia delivery modifiers, providers may append Modifier GC: "*This service has been performed in part by a resident under the direction of a teaching physician*."

V. **AA vs. CRNA**:

A. An Anesthesiologist Assistant (AA) is a non-physician anesthesia provider.
   1. They are required by law to work only under the medical direction and supervision of an anesthesiologist.

B. A Certified Registered Nursing Anesthetist (CRNA) has a board certification in anesthesia.
   1. They have the ability to practice independently, or under the medical direction of an anesthesiologist or other physician.

VI. **Anesthesia Time**:

A. This is defined as the period during which an anesthesia practitioner is continuously present with the patient. It starts when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the patient (i.e.; when the patient may be placed safely under postoperative care).

B. To bill for anesthesia services, bill the total anesthesia time expressed in minutes in box 24G on the HCFA1500/professional claim form. Network Health will convert the total minutes into units which equals one (1) unit for every fifteen (15) minutes of administered anesthesia.

C. Per the ASA RVG, when multiple surgical procedures are performed during a single anesthetic administration, only the anesthesia delivery service code with the highest basic value is reported. The time reported is the combined total for all procedures. ASA anesthesia add-on codes reported with a primary procedure are an exception to this coding rule. They are listed in addition to the code for the primary procedure. Surgical add-on codes reported for general or monitored anesthesia are not reimbursable per the ASA Crosswalk Guide.

VII. **Qualifying Circumstances**:

A. Per ASA guidelines, many anesthesia services are provided under particularly difficult circumstances depending on factors such as extraordinary condition of the patient, notable operative conditions, or unusual risk factors. Qualifying circumstances codes identify conditions that significantly impact the character of anesthesia services provided. Qualifying circumstances codes are not submitted alone but in addition to the anesthesia delivery service code and documentation must reflect the need for billing the additional code.

B. The following describe scenarios which are considered add-on services:
   1. CPT 99100 - Anesthesia for patient of extreme age, younger than 1 year and older than 70

2. CPT 99116 - Anesthesia complicated by utilization of total body hypothermia
3. CPT 99135 - Anesthesia complicated by utilization of controlled hypotension
4. CPT 99140 - Anesthesia complicated by emergency conditions (must specify). An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part.

When one of the above codes is billed with a place of service (POS) other than 23/Emergency Room, or without a reason for the emergency anesthesia noted in box 19 of the HCFA1500/professional claim form, Network Health may request the operative report.

Regulatory Citations:
American Society of Anesthesiology Relative Value Guide
ASA Crosswalk Guide
Centers for Medicare and Medicaid Services (CMS)

Effective Date: 1/1/2011
Update Date: 10/23/2023
Next Review Date: 10/24/2024