

Reimbursement Clinical Guidelines: Anesthesia Professional Reimbursement Policy

Policy Position

This reimbursement policy applies to FirstCare Health Plans' Commercial (HMO, PPO, SF) anesthesiologists rendering anesthesia based on medical necessity. Assures anesthesia reimburse appropriately and according to medically necessity, guidelines and the member's health benefit plan.

Disclaimer

FirstCare has developed coding and reimbursement policies ("Reimbursement Policies") to provide ready access and general guidance on reimbursement methodologies for medical, surgical and behavioral health services.

These policies are subject to all terms of the Provider Service Agreement as well as changes, updates and other requirements of Reimbursement Policies. All Reimbursement Policies are also subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD-10), FirstCare accepts codes valid for the date of service. Additionally, Reimbursement Policies supplement certain standard FirstCare benefit plans and aid in administering benefits. Thus, federal and state law, contract language, etc. take precedence over the Reimbursement Policies (e.g., Centers for Medicare and Medicaid Services [CMS] National Coverage Determinations [NCDs], Local Coverage Determinations [LCDs] or other published documents). Moreover, the terms of a member's particular Benefit Plan, Evidence of Coverage, Certificate of Coverage, etc., may differ significantly from Reimbursement Policies. For example, a member's benefit plan may contain specific exclusions related to the topic addressed in Reimbursement Policies.

Most importantly, our Reimbursement Policies relate exclusively to the administration of health benefit plans and are **not** recommendations for treatment or treatment guidelines. Providers are responsible for the treatment and recommendations provided to the member.

Providers and their office staff must use self-service channels to verify effective dates and copayments for commercial members prior to initiating services. Copayments, deductible, and/or coinsurance may apply depending upon the member's benefit plan specific.

All Reimbursement Policies are subject to change prior to the annual review date. Lines of business (LOB) are subject to change without notice; individual Reimbursement Policies list the applicable LOBs.

Medical Necessity

Anesthesia Base Units and Time Factors. Each CPT anesthesia code is assigned a Base Value by the ASA, and FirstCare uses these values for determining reimbursement. The time units and modifying units vary with each case, but the base units are constant for a given procedure. According to the American Society of Anesthesiologists (ASA), the units paid are determined by adding the anesthesia base units and covered modifying units plus time units. ASA assigns base unit values to most surgical procedures. They reflect the difficulty of the anesthesia services, including the usual preoperative and postoperative care.

Anesthesia time is defined as the continuous presence of the anesthesiologist or anesthetist. It starts when the patient is first prepared for anesthesia care and ends when the patient is placed under postoperative supervision. Time units are determined based on one (1) time unit for each 15 minutes of anesthesia. Report the actual anesthesia time in minutes. When actual anesthesia time is not in equal increments of 15 minutes, time units are computed by dividing the reported anesthesia time by 15 minutes, and rounding to one decimal place (nearest 10th). If system constraints prohibit rounding using decimal, FirstCare rounds up to allow a full-time unit when the actual anesthesia time is or exceeds eight (8) minutes of a single 15-minute time unit.

Physical Status and Qualifying Circumstances. Many anesthesia services are provided under different circumstances and/or when the patient's physical status is impaired. This adds to the complexity of the anesthesia service and may be reported by utilizing physical status modifiers and/or qualifying circumstance codes. When reporting these modifiers/codes, additional ASA units may be allowed and combined with the base unit value for the anesthesia service performed.

Medical and Surgical Services Provided by Anesthesiologists. In addition to providing anesthesia care, anesthesiologists may perform the following medically necessary surgical and medical services, which are subject to all current claims processing guidelines:

- Swan-Ganz catheter insertion
- Central Venous Pressure (CVP) line insertion
- Intra-arterial lines insertion
- Transesophageal echocardiography

An anesthesiologist may provide emergency intubation (CPT 31500) services. However, these services are considered to be an integral part of the anesthesia care, whether provided in an emergency or not, and are included in the base anesthesia services. Emergency intubation not rendered in conjunction with anesthesia services is reimbursable.

Administering Nerve Blocks: CPT 64400 – 64530. Time spent by an anesthesiologist administering a nerve block (i.e.; injecting an anesthetic agent into or around a given nerve) is included in the total anesthesia time. Therefore, it is not eligible for separate reimbursement.

- 64400 Injection, anesthetic agent; trigeminal nerve, any division or branch
- 64402 Injection, anesthetic agent; facial nerve
- 64405 Injection, anesthetic agent; greater occipital nerve
- 64408 Injection, anesthetic agent; vagus nerve
- 64410 Injection, anesthetic agent; phrenic nerve
- 64413 Injection, anesthetic agent; cervical plexus
- 64415 Injection, anesthetic agent; brachial plexus, single
- 64416 Injection, anesthetic agent; brachial plexus, continuous infusion by catheter (including catheter placement)
- 64417 Injection, anesthetic agent; axillary nerve
- 64418 Injection, anesthetic agent; suprascapular nerve
- 64420 Injection, anesthetic agent; intercostal nerve, single
- 64421 Injection, anesthetic agent; intercostal nerves, multiple, regional block
- 64425 Injection, anesthetic agent; ilioinguinal, iliohypogastric nerves
- 64430 Injection, anesthetic agent; pudendal nerve

Additional reimbursement is warranted when identified as a distinct procedure by use of modifier-59, for example, if a nerve block is performed primarily for postoperative pain management. Please note that appropriate use of this modifier may be subject to review and all current claim-processing guidelines. When the nerve block is billed alone and is for the treatment of a non-surgical condition, it should be billed under the appropriate injection/block code. FirstCare allows separate reimbursement for covered non-surgical nerve block procedures subject to all current claims processing guidelines.

Administering Conscious Sedation: CPT 99151-99152. FirstCare does not provide separate reimbursement for conscious sedation. These codes are not billable by anesthesiologists. Further, conscious sedation administered in conjunction with diagnostic, therapeutic, or minor procedures are considered integral to the provision of the primary service.

Patient Controlled Analgesia. Patient controlled analgesia (PCA) pain management involves the self-administration of intravenous drugs through an infusion device. When PCA is initiated, FirstCare reimburses the initial catheter insertion, if not part of a surgical anesthesia. Time units and anesthesia base units are not applicable in this instance. FirstCare provides reimbursement for postoperative PCA

evaluation and management services when billed with an appropriate evaluation and management code, with appropriate supporting documentation.

Epidural Anesthesia. Epidural anesthesia involves the administration of a narcotic drug either through an epidural catheter or by single dose injection. When eligible, FirstCare reimburses for the insertion of the epidural catheter and injection when reported with CPT codes 62320, 62321, 62322, 62323, 62324, 62325, 62326, 62327.

- 62320 Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance
- 62321 Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (i.e., fluoroscopy or CT)
- 62322 Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance
- 62323 Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (i.e., fluoroscopy or CT)
- 62324 Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance
- 62325 Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (i.e., fluoroscopy or CT)
- 62326 Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance
- 62327 Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (i.e., fluoroscopy or CT)

With the exception of obstetrical care (see below), if an epidural is the mode of anesthesia for a surgical procedure, reimbursement is based on the surgical procedures base and time units. Separate reimbursement is not provided for the epidural insertion. When providing epidural-related services for obstetrical care, the actual anesthesia time should be reported.

When eligible, FirstCare reimburses:

- One (1) time unit per hour of labor for obstetrical patients receiving a continuous infusion epidural.
- One (1) time unit for each 15 minutes of actual delivery time. In the absence of a definitive time, FirstCare uses a delivery time of one (1) hour.
- Continuous epidural anesthesia on labor and delivery services should be reported using either ASA code 01967 (vaginal delivery) or codes 01967 and 01968 (cesarean delivery).
- If the mode of anesthesia during labor is converted to general anesthesia for the delivery, report ASA code 01960 (vaginal delivery) or code 01961 (cesarean delivery) plus the labor and delivery time. FirstCare reimburses for these base/time units in addition to units relating to anesthesia service (labor epidural).

Postoperative and Therapeutic Pain Management. Various methods of postoperative and therapeutic pain management exist, including the use of epidural analgesia. Epidural analgesia involves the administration of a narcotic drug or local anesthetic either through an epidural catheter or by a single dose injection. FirstCare reimburses the eligible insertion of the epidural when performed for therapeutic, non-surgical, pain management.

- Epidural and nerve blocks performed for postoperative pain management, if they are not the mode of anesthesia, are eligible for reimbursement when identified by modifier-59 as a distinct procedure.
- Daily management of the therapeutic epidural administration (ASA code 01996) are considered eligible and a separately reimbursable service once per date of service excluding the day of insertion.
- Reimbursement will not be allowed for both the catheter insertion and the daily management of the drug when done on the same day.
- Daily management services beyond three (3) days are subject to clinical review to determine if the service(s) meet Coverage Policy Bulletin guidelines.

Mobile Anesthesia Charges. FirstCare does not provide separate reimbursement for the use of office equipment needed for administration of anesthesia regardless of whether it is onsite or must be transported to the physician's office. For office-based surgical procedures, charges for the transportation and set up of equipment for the administration of anesthesia are not eligible for reimbursement. Transportation and setup of equipment is considered incidental to and included in the global surgical package for the procedure performed and is not separately payable.

Certified Registered Nurse Anesthetist (CRNA). A Certified Registered Nurse Anesthetist (CRNA) is a registered nurse who is licensed by the state in which they practice. FirstCare recognizes a CRNA as an eligible practitioner under a signed provider contract or state mandate.

Reimbursement for the administration of anesthesia under these circumstances is based on the base unit value assigned to the surgical procedure plus time units and eligible modifying units (if any). Medically directed CRNA services will be paid at 50% of the calculated reimbursement. A separate charge for the medical direction by a physician will be considered, up to the remaining 50%, when billed by the physician. When a CRNA is not medically directed, the full allowed rate is considered payable to the CRNA. FirstCare will not pay more than 100% of the total eligible calculated reimbursement for the combined medical direction and CRNA services.

Medical Direction and Supervision of Anesthesia Administration. FirstCare considers the personal medical direction by a physician or anesthesiologist of a qualified CRNA as eligible reimbursement.

When billing for the medical direction of anesthesia procedures, use the following HCPCS modifiers:	
Code	Description
AD	Medical supervision by a physician; more than four (4) concurrent anesthesia procedures.
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals.
QY	Medical direction of one (1) CRNA by an anesthesiologist.

Reimbursement for the administration of anesthesia under these circumstances is based on the base unit value assigned to the surgical procedure plus time units and eligible modifying units (if any). Reimbursement for the physician or anesthesiologist's medical direction service is determined based on up to 50% of the allowance of the procedure performed. A charge for the medically directed or supervised CRNA service will be considered, up to the remaining 50%, when billed separately. FirstCare does not reimburse more than 100% of the total eligible calculated reimbursement for the combined medical direction/supervision and CRNA services.

Monitored Anesthesia Care (MAC) Anesthesia Assistance with Elective: Gastrointestinal Endoscopic Procedures. Gastrointestinal endoscopic procedures are routinely performed with the use

of intravenous sedation and analgesia. The level of anesthesia required to relieve patient anxiety and discomfort can vary from patient to patient. Sedation is a necessary component of a safe and effective gastrointestinal endoscopic procedure, and the majority of these are colonoscopies and esophagogastroduodenoscopies. Conscious sedation for these procedures can be safely and effectively administered under the direction of the gastroenterologist performing the procedure. Most gastroenterologists are trained to do this, and the work and reimbursement for these services are included in the reimbursement for the procedure.

Based on guidelines from the Society of Gastrointestinal Endoscopy and the American Society of Anesthesia (ASA), certain patients are categorized as higher than normal risk for sedation-related complications. Because of this risk, it is reasonable for an anesthesiologist or nurse anesthetist to administer the sedation and monitor the patient during the endoscopic procedure.

Based on input from academic societies and anesthesiologists in the provider community regarding MAC services, FirstCare reimburses MAC services when performed in an inpatient or outpatient setting and when billed with the appropriate physical status modifier listed within this reimbursement policy.

When reporting MAC, always use one of the following HCPCS modifiers:

Modifier	Description
QS	Monitored anesthesia care service.
G8	Monitored anesthesia care for deep complex, complicated, or markedly invasive surgical procedure.
G9	Monitored anesthesia care for patient who has a history of severe cardiopulmonary disease.

Since clear and complete documentation is a factor in the provision of quality care, FirstCare monitors the appropriate use of the above MAC modifiers and physical status modifiers. Effective November 1, 2014, FirstCare does not reimburse MAC procedures inclusive to a primary service for memberships without a “high-risk” condition. FirstCare considers the use of monitored anesthesia care **not medically necessary** for gastrointestinal procedures in patients at average risk. FirstCare considers medically necessary all “high risk” or anesthesia risk category III or greater based on ASA Physical Status Classification System when there is increased risk for complication because of severe comorbidity.

- Increased risk for airway obstruction or anatomic variant associated with difficult intubation. For example:
 - History of stridor
 - Dysmorphic facial features, such as Pierre Robin syndrome or Trisomy 21
 - Oral abnormalities, such as a small opening (<3 cm in an adult) or macroglossia
 - Neck abnormalities, such as limited neck extension, neck mass, or tracheal deviation
 - Jaw abnormalities, such as micrognathia (small jaw), retrognathia, trismus (reduced opening secondary to muscle spasm)
- General Medical:
 - History of adverse reaction to sedation or inadequate response to moderate sedation
 - Active alcohol or substance abuse
 - Morbid obesity (B.M.I. 40 or higher)
 - Pregnancy
 - Less than 18-years-of-age

Unusual Anesthesia (CPT Modifier-23). Under unusual circumstances, general anesthesia may be performed for procedures that typically require local or regional anesthesia or no anesthesia at all. The modifier, “23” should be submitted with the appropriate procedure code to report unusual anesthesia. This modifier should not be reported with procedure codes that include the term, “without anesthesia” in the description or for procedures that are normally performed under general anesthesia.

FirstCare will review unusual anesthesia claim submissions on an individual consideration basis and will provide reimbursement for medically necessary services at the allowance rate of three base units per

procedure plus time units and eligible modifying units (if any). Documentation to support the reported service must be provided with the claim.

Applicable Billing Codes

Commercial Reimbursable Anesthesia Service Codes

Reimburse additional anesthesia units for the following physical status modifiers:	
Physical Status Modifiers	Description
23	Unusual Anesthesia
P3	A patient with severe systemic disease
P4	A patient with severe systemic disease that is a constant threat to life
P5	A moribund patient who is not expected to survive without the operation

Reimburse additional anesthesia units for the following qualifying circumstances:	
CPT Code	Description
99116	Anesthesia complicated by utilization of total body hypothermia (List separately in addition to code for primary anesthesia procedure)
99135	Anesthesia complicated by utilization of controlled hypotension (List separately in addition to code for primary anesthesia procedure)

Reimburse MAC (service codes below) when billed with modifier P3, P4, P5:	
Code	Description
00731	Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; not otherwise specified
00732	Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; endoscopic retrograde cholangiopancreatography (ERCP)
00811	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified
00812	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy
00813	Anesthesia for combined upper and lower gastrointestinal endoscopic procedures, endoscope introduced both proximal to and distal to the duodenum

Do not reimburse additional units or MAC for the following:	
Codes	Description
99100	Anesthesia for a patient of extreme age (under 1-year-of-age and over 70-years-old)
99140	Anesthesia complicated by emergency condition
P1	A normal, healthy patient
P2	A patient with mild systemic disease
P6	A declared brain-dead patient whose organs are being removed for donor purpose

HEALTH PLANS

Do not reimburse separately and the following are not reimbursable by an anesthesiologists:	
CPT Code	Description
99151	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient younger than 5 years of age
99152	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes intraservice time (List separately in addition to code for primary service)

Reimburse under the physician fee schedule the following services when furnished by the anesthesiologist:	
CPT Code	Description
93503	Swan-Ganz catheter insertion
36555	Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age
36556	Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older
36568	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; younger than 5 years of age
36569	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; age 5 years or older
36580	Replacement, complete, of a non-tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access
36584	Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access
36620	Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous
36625	Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); cutdown
93312	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report
93313	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); placement of transesophageal probe only
93314	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); image acquisition, interpretation and report only
93315	Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report
93316	Transesophageal echocardiography for congenital cardiac anomalies; placement of transesophageal probe only
93317	Transesophageal echocardiography for congenital cardiac anomalies; image acquisition, interpretation and report only
93318	Echocardiography, transesophageal (TEE) for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis

Reimburse CRNAs for covered CRNA services when reported with one of the following HCPCS modifiers:	
Modifier	Description
QX	CRNA service with medical direction by a physician.
QZ	CRNA service without medical direction by a physician.

Definitions

Word/Term/Abbreviation	Definition
Deep Sedation	A drug-induced depressed level of consciousness that patients cannot be easily aroused but respond purposefully after repeated or painful stimuli. Airway intervention may be required. Patients may require assistance to maintain a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.
Epidural Anesthesia	The administration of a narcotic drug either through an epidural catheter or by a single dose injection.
General anesthesia	A drug induced loss of consciousness in which patients are not arousable even by painful stimuli. Patients require assistance in maintaining a patent airway; positive pressure ventilation may be required due to depressed spontaneous ventilation or drug induced depression or neuromuscular function. Cardiovascular function may be impaired.
MAC	Monitored Anesthesia Care
Micrognathia	A lower jaw that is smaller than normal.
Minimal Sedation	A drug induced state that patients respond normally to verbal commands and airway, ventilation, and cardiovascular function remain unaffected.
Moderate Sedation (conscious sedation)	A drug-induced depressed level of consciousness that patients can purposefully respond to verbal command or tactile stimulation. No airway intervention is required. Ventilation is adequate and cardiovascular function is usually maintained.
Patient Controlled Analgesia (PCA)	Pain management that involves the self-administration of intravenous drugs through an infusion device.
Pierre Robin syndrome	A condition present at birth, in which the infant has a smaller-than-normal lower jaw, a tongue that falls back in the throat, and difficulty breathing.
Retrognathia	A condition in which either or both jaws recede with respect to the frontal plane of the forehead.
Trismus	Inability to open the mouth fully.
Trisomy 21	"Down syndrome" Trisomy 21 is caused by an extra chromosome (chromosome 21) originates in the development of either the sperm or the egg.

Related Policies and References

1. American Society of Anesthesiologists (ASA). Retrieved from <https://www.asahq.org/quality-and-practice-management/standards-guidelines-and-related-resources-search>
2. American Society of Anesthesiologists (ASA) Distinguishing monitored anesthesia care ("MAC") from moderate sedation/analgesia. Amended October 21, 2009. Last accessed August 2012.
3. American Society of Anesthesiologists (ASA). Position on monitored anesthesia care (Amended October 16, 2013). 2013
4. American Society of Anesthesiologists Task Force on Sedation and Analgesia by NonAnesthesiologists. Practice guidelines for sedation and analgesia by non-anesthesiologists. *Anesthesiology* 2002; 96: 1004-17
5. Sedation and anesthesia in GI endoscopy. Accessed on November 14, 2013. Retrieved from <https://www.guideline.gov/>