

Policy 1205

NHP/NHIC ~ Anesthesia Policy

Purpose: This is to provide guidelines for Network Health Plan/Network Health Insurance Corporation (NHP/NHIC) policy on reimbursable anesthesia services.

Policy and Procedure: Anesthesia should always be provided by a physician or a nurse with specialty training, or by a specially trained anesthesia assistant. NHP/NHIC's reimbursement policy for anesthesia services is developed in part to identify services rendered using the American Society of Anesthesiology (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.

The ASA defines anesthesiology as "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 other diagnostic or therapeutic procedures.
- The evaluation and management of essential physiologic functions under the stress of anesthetic and surgical manipulations.
- The clinical management of the patient unconscious from whatever cause.
- The evaluation and management of acute or chronic pain.
- The management of problems in cardiac and respiratory resuscitation.
- The application of specific methods of respiratory therapy.
- The clinical management of various fluid, electrolyte and metabolic disturbances."

Medicare uses the term certified registered nurse anesthetists to include CRNAs and anesthesia assistants (AA). However, the qualifications vary for the two practitioners.

According to CMS, a CRNA is a state-licensed registered nurse who either:

- Has a current certification from the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists.
- Graduated from a nurse anesthesia program that meets the standards of the Council of Accreditation of Nurse Anesthesia Educational Programs within the past year and a half and is awaiting his or her initial certification.

An AA is a professional permitted to administer anesthesia by state law and who has successfully completed a six-year program for AAs. Two of the six years must consist of specialized academic and clinical training in anesthesia.

Anesthesia is further defined by the following four general types:

- **Local** – Infiltration of anesthetic agents to a limited area, used for minor procedures such as biopsies, and the excision of skin tumors and lesions.
- **General** – Total loss of consciousness and reflexes due to administration of drugs and inhalation agents.
- **Monitored anesthesia care** – Induced by the administration of intravenous drugs, conscious sedation may vary from minimal to significant awareness with retention of protective reflexes.
- **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.

How to calculate anesthesia time: Anesthesia time, which involves the continuous actual presence of the anesthesiologist or anesthetist, begins when the physician or anesthetist begins to prepare the patient for induction, and ends when the anesthesiologist is no longer in personal attendance.

Reimbursement: The following CPT codes 00100-01999 and 99100-99140 are applicable for billing anesthesia services.

To bill for anesthesia services bill the total anesthesia time expressed in minutes in item 24G on the HCFA CMS-1500 form. NHP/NHIC will then convert the total minutes into units, which is 1 unit for every 15 minutes of administered anesthesia.

Preoperative and postoperative visits, administration of fluids and/or blood products, and usual monitoring services, such as heart rate, oximetry, and blood pressure monitoring, are basic components of anesthesia care performed during a surgical procedure and are not separately reimbursable services.

Unusual monitoring services, such as intra-arterial, central venous, and flow-directed catheters (e.g., Swan-Ganz), and use of transesophageal echocardiography (TEE), are separately reimbursable services.

As 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 services per the ASA Crosswalk Guide.

Modifier Submission: All services reported for anesthesia delivery services must be submitted with the appropriate HCPCS modifiers:

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| AA | Anesthesia services performed personally by anesthesiologist. |
| AD | Medical supervision by a physician: more than four concurrent anesthesia procedures. |
| G8 | Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure. |
| G9 | Monitored anesthesia care for patient who has history of severe cardiopulmonary condition. |
| QK | Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals. |
| QS | Monitored anesthesia care service. |
| QX | CRNA service; with medical direction by a physician. |
| QY | Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist. |
| QZ | CRNA service; without medical direction by a physician. |

A teaching anesthesiologist participating in a single anesthesia procedure with a resident or a student registered nurse anesthetist should report modifier AA.

A teaching anesthesiologist participating in the medical direction of two concurrent anesthesia procedures involving residents may report modifier AA or modifier QK. A teaching anesthesiologist involved in three or four resident cases should report modifier QK.

A teaching anesthesiologist participating in the medical direction of two concurrent anesthesia procedures involving either two student registered nurse anesthetists, or involved in one procedure with a student registered nurse anesthetist and involved with a second concurrent procedure with a certified registered nurse anesthetist, anesthesiologist assistant, intern, or resident should report modifier QK.

NHP/NHIC will reimburse 50% of the allowable amount when anesthesia services are submitted with modifiers QK, QX, and QY.

Modifier GC may be appended for informational purposes only in addition to a required anesthesia delivery service modifier to indicate the service was performed in part by a resident under the direction of a teaching physician.

ASA guidelines identify physical status modifiers to distinguish various levels of complexity of anesthesia services provided. Appending a physical status modifier to a time-based anesthesia code identifies the complexity. The physical status modifiers are:

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| P1 | A normal healthy patient |
| P2 | A patient with mild systemic disease |
| 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 |
| P6 | A declared brain-dead patient whose organs are being removed for donor |

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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. Add on codes:

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| 99100 | Anesthesia for patient of extreme age, younger than 1 year and older than 70. |
| 99116 | Anesthesia complicated by utilization of total body hypothermia. |
| 99135 | Anesthesia complicated by utilization of controlled hypotension. |
| 99140 | Anesthesia complicated by emergency conditions (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 CPT 99140 is billed with a POS other than 23 (Emergency Room) or without a reason for the emergency anesthesia noted in box 19 of the HCFA claim form, NHP/NHIC may request operative reports when reviewing and considering the claims.

The same qualifying circumstances code submitted more than once for the same date of service is reimbursed only once per anesthesia delivery service.

Monitored Anesthesia care (MAC) is a reimbursable time-based service when the appropriate monitored anesthesia modifier, i.e. QS, G8, or G9, is appended to the anesthesia delivery service indicating MAC was provided. MAC may include varying levels of sedation, analgesia and anxiolysis as necessary. Per the ASA, MAC prerequisites mandate that the provider of MAC is prepared and qualified to convert to general anesthesia and competent to rescue a patient's airway from any sedation-induced compromise. MAC includes but is not limited to:

- performance of a pre-anesthetic examination and evaluation;
- prescription of the anesthesia care required;
- diagnosis and treatment of clinical problems that occur during the procedure;
- support of vital functions;
- administration of sedatives, analgesics, hypnotics, anesthetic agents or other medications necessary for patient safety;
- psychological support and physical comfort; and
- provision of indicated postoperative anesthesia care.

Moderate (conscious) sedation does not include MAC. Moderate sedation rendered by an attending physician or a second physician or other health care professional should be reported with CPT codes 99143-99150.

Intravascular Catheterization Procedures: According to the ASA, placement of an arterial catheter, central venous catheter, and/or flow directed pulmonary artery catheter may be required for more precise information for safe and effective anesthesia and life support in the peri-operative period.

The interpretation of the data obtained from this monitoring is accounted for in the usual anesthesia fee. However, placement of the catheters is considered a separately reimbursable service. The necessity for the procedure is driven more by the patient's condition than by the surgical procedure. Not all patients undergoing the same surgical procedure require the same degree of monitoring. ASA guidelines identify CPT codes: 36555, 36556, 36620, 36625, and 93503 which are separately reimbursable for intravascular catheterization procedures.

Transesophageal Echocardiography (TEE): The following is based on ASA guidelines placement of the TEE probe, image acquisition, interpretation and report of the information are medical services provided by anesthesiologists or other qualified physicians. Indications for TEE are usually based on the individual patient's condition rather than the specific surgical procedure. Due to the individual consideration, the TEE procedure is not considered part of the routine anesthesia care and is considered a separately reimbursable service. Per ASA guidelines, for TEE the CPT codes are: 93312-93318 which will be separately reimbursed.

Medical Direction Services: Per CMS guidelines, medical direction services are reimbursable when the anesthesiologist supervises CRNA's, anesthesia assistants, or other qualified people in one to four concurrent procedures. According to CMS guidelines, medical direction of qualified persons by the anesthesiologist is a reimbursable service provided that the anesthesiologist meets all of the following criteria:

- performs a pre-anesthetic examination and evaluation,
- prescribes the anesthesia plan,
- personally participates in the most demanding procedures of the anesthesia plan, including the induction and emergence,
- ensures that any procedures in the anesthesia plan are performed by a qualified anesthetist,
- monitors the course of anesthesia administration at intervals,
- remains physically present and available for immediate diagnosis and treatment of emergencies,
- provides indicated post-anesthesia care

Claims submitted by CRNAs for services to multiple patients at the same time are not reimbursable services.

Epidural/Nerve Anesthesia for Surgical Procedures: Epidural or major nerve anesthesia for post-operative pain management involves obtaining regional anesthesia of shoulder, pelvis, genital, or other areas by injection of a local anesthetic into the epidural space or major nerve. Anesthesia and CPT codes for

epidural or major nerve anesthesia and pain management are 01996, 62310-62319, 64400-64450, and 64505-64530.

The insertion and administration of an epidural or major nerve catheter (CPT codes 62318, 62319, 64416, 64446, 64448 and 64449) by an anesthesiologist for anesthesia purposes during a surgical procedure is included in the anesthesia delivery service code and is not separately reimbursable. The appropriate anesthesia or surgical code must be submitted with an anesthesia modifier(s) and time for the procedure.

An injection or catheter insertion into the epidural space or major nerve before, during, or following the surgical procedure for postoperative pain management is a separately reimbursable service. An appropriate modifier to indicate a distinct procedural service was performed should be appended to the appropriate procedure code: 62310-62319, 64400-64450, and 64505-64530.

Daily hospital management of the epidural or subarachnoid drug administration (CPT code 01996) in CMS place of service 21 (inpatient setting), 22 (outpatient hospital) or 25 (birthing center) is a separately reimbursable service once per date of service excluding the day of surgery. CPT code 01996 is considered included in the anesthesia procedure if submitted on the same date of service by the same individual physician or other health care professional.

Per CPT guidelines, if a physician provides the regional or general anesthesia for a surgical or medical procedure he/she performed, modifier 47 should only be appended to the code for the basic medical or surgical procedure. The medical or surgical procedure appended with modifier 47 should be submitted on a single claim line, e.g., 25260-47.

NHP will not reimburse for anesthesia management services reported with CPT codes 00100-01999 (excluding 01953 and 01996) appended with modifier 47.

NHP aligns with CMS guidelines by not allowing separate payment for regional or general anesthesia services performed by the physician who also furnishes the medical or surgical service, excluding moderate sedation. In these situations, the allowance for the anesthesia service is included in the payment for the medical or surgical service.

Preop/Postop Visits: NHP aligns with CMS by considering Evaluation and Management (E/M) codes to be part of the anesthesia management service on the same date of service anesthesia management was provided by the same specialty physician or other health care professional of the same group and same specialty reporting the same federal tax identification number. Critical care evaluation and management CPT code 99291-99292 may be submitted with modifier 24 or 25 to indicate a significant and separately identifiable service by the same physician on the same day as an anesthesia delivery service was rendered. When the physician or other health care professional is providing an E/M service on the day after the anesthesia delivery service, the appropriate E/M code may be submitted with

modifier 24 indicating an unrelated E/M service was rendered during a postoperative period.

Epidural/Nerve Anesthesia for Pain Management: Epidural or major nerve anesthesia for pain management involves obtaining regional anesthesia of shoulder, pelvis, genital, or other areas by injection of a local anesthetic into the epidural space or major nerve. Anesthesia and CPT codes for epidural or major nerve anesthesia and pain management are 01996, 62310-62319, 64412-64425 and 64445-64450.

An injection or catheter injection into the epidural space or major nerve for pain management services by an anesthesiologist is a reimbursable service. The appropriate CPT codes (62310-62319, 64412-64425 and 64445-64450) submitted without other anesthesia delivery codes(s) indicate one-time injection or insertion for pain management. The pain management service is reimbursed without time units.

Daily hospital management of epidural or subarachnoid drug administration (CPT code 01996) in a CMS place of service 21 (inpatient hospital), 22 (Outpatient hospital), or 25 (birthing center) is a separately reimbursable service per date of service excluding the day of insertion. CPT 01996 is considered included in the pain management procedure if submitted on the same date of service by the same individual physician or other health care professional. If the anesthesiologist continues with the patient's care after discharge, the appropriate Evaluation and Management code should be used.

An injection or catheter insertion into the epidural space or major nerve for pain management services by physicians other than anesthesiologists is a separately reimbursable service with the appropriate CPT code(s). Reimbursement for subsequent monitoring services (01996) is considered included in the daily E/M visit codes and not separately reimbursed.

Patient-Controlled Analgesia (PCA): most often involves either the insertion of an intravenous catheter or an epidural catheter, which is used to administer an anesthetic/narcotic at a rate that is controlled by the patient. PCA may be administered through the following types of catheters billed with CPT code 36000, 36410, 62318 or 62319.

Insertion of an intravenous catheter for PCA with CPT code 36000 or 36410 submitted without other services is a separately reimbursable service at a one-time insertion rate. Time units are not reimbursed.

Insertion of an epidural catheter for PCA with CPT code 62318 or 62319 inserted before, during, or following a surgical procedure is a reimbursable service. Modifier would need to be appended to the procedure code to indicate that a distinct procedural service was performed.

Labor and Delivery Services Reimbursement: CPT codes 01958-01967 and add-on codes 01968, 01969 are considered reimbursable as indicated below.

The insertion and administration of an epidural (CPT codes 62310, 62311, 62318 or 62319) by a physician or other health care professional for anesthesia purposes during the labor and delivery is included in the anesthesia delivery service code and is not separately reimbursable. The appropriate anesthesia CPT codes 01960 or 01967 for vaginal delivery and CPT codes 01961 or 01967 with 01968 or 01969 for cesarean delivery must be submitted with an anesthesia modifier(s) and time for procedure.

An injection or catheter insertion into the epidural space or major nerve before, during or following the surgical procedure for postoperative pain management is a separately reimbursable service. Appropriate modifier must be appended to the appropriate procedure code (62310-62319, 64412-64425 and 64445-64450) to indicate a distinct procedural service was performed.

Daily hospital management of epidural or subarachnoid drug administration (CPT code 01996) in a CMS place of service 21 (inpatient hospital), 22 (outpatient hospital), or 25 (birthing center) following a cesarean or vaginal delivery is a separately reimbursable service once per date of service excluding the date of delivery. CPT code 01996 is considered included in the anesthesia procedure if submitted on the same date of service by the same individual physician or other health care professional.

The add-on code concept in CPT applies only to add-on procedures or services performed by the same specialty physician or health care professional. Same specialty physician or other health care professionals are defined as a physician and/or other health care professional of the same group and same specialty reporting the same Federal Tax Identification number.

This policy is not a guarantee of coverage or payment. The claim(s) will be denied if it does not meet with all the terms and provisions of the members Certificate of Coverage. Actual benefits will be determined when the claim(s) or bill(s) are submitted to NHP/NHIC. NHP/NHIC reserves the right to periodically review and update all claims policies and procedures.

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