Private Property of Florida Blue
This payment policy is Copyright 2019, Florida Blue. All Rights Reserved. You may not copy or use this document or disclose its contents without the express written permission of Florida Blue. The medical codes referenced in this document may be proprietary and owned by others. Florida Blue makes no claim of ownership of such codes. Our use of such codes in this document is for explanation and guidance and should not be construed as a license for their use by you. Before utilizing the codes, please be sure that to the extent required, you have secured any appropriate licenses for such use. Current Procedural Terminology (CPT) is Copyright 2019 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use. CPT® is a trademark of the American Medical Association.

PAYMENT POLICY ID NUMBER: 10-003

Original Effective Date: 11/15/2008

Revised: 06/20/2019

Anesthesia Services

THIS PAYMENT POLICY IS NOT AN AUTHORIZATION, CERTIFICATION, EXPLANATION OF BENEFITS, OR A GUARANTEE OF PAYMENT, NOR DOES IT SUBSTITUTE FOR OR CONSTITUTE MEDICAL ADVICE. ALL MEDICAL DECISIONS ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND PHYSICIAN. BENEFITS ARE DETERMINED BY THE GROUP CONTRACT, MEMBER BENEFIT BOOKLET, AND/OR INDIVIDUAL SUBSCRIBER CERTIFICATE IN EFFECT AT THE TIME SERVICES WERE RENDERED. THIS PAYMENT POLICY APPLIES TO ALL LINES OF BUSINESS AND PROVIDERS OF SERVICE. IT DOES NOT ADDRESS ALL POTENTIAL ISSUES RELATED TO PAYMENT FOR SERVICES PROVIDED TO BCBSF MEMBERS AS LEGISLATIVE MANDATES, PROVIDER CONTRACT DOCUMENTS OR THE MEMBER'S BENEFIT COVERAGE MAY SUPERSEDE THIS POLICY.

DESCRIPTION:

Anesthesia services consist of the administration of an anesthetic agent, typically by injection or inhalation, causing partial or complete loss of sensation, with our without loss of consciousness.

These services are provided as one of the following types of anesthesia:

- Regional – the use of local anesthetic agents to produce circumscribed areas of loss of sensation. Regional anesthesia can include nerve blocks, spinal, epidural, and field blocks. Epidural anesthesia is produced by injection of an anesthetic agent into the epidural space.
- Local – infiltration or topical application of an anesthetic agent at or near the site where the procedure is to be performed, creating loss of sensation to the area.
- General – loss of the ability to perceive pain, associated with loss of consciousness, produced by intravenous infusion of drugs or inhalation of anesthetic agents.
- Monitored Anesthesia Care (MAC) – intraoperative monitoring by a physician or other qualified individual under the medical direction of the physician, of the patient's vital physiological signs in anticipation of the need for administration of general anesthesia or of the development of adverse physiological patient reaction to the surgical procedure.
- Moderate Sedation – moderate (conscious) sedation is defined by the American Society of Anesthesiologists as a drug-induced depression of the consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

REIMBURSEMENT INFORMATION:

Anesthesia services are **eligible for coverage** when:

- The procedure for which the anesthesia is administered is a covered service
- The anesthesia is administered by a:
  - Physician (other than the operating physician, assistant surgeon, or obstetrician) qualified to administer general anesthesia or to appropriately supervise anesthesia, OR
  - Certified registered nurse anesthetist (CRNA), OR
  - Anesthesiologist assistant (AA)

The usual pre-operative and post-operative visits and consultations, the anesthesia care during the procedure, the administration of fluids and/or blood, and the usual monitoring services (e.g., ECG, temperature, blood pressure, oximetry, capnography and mass spectrometry) are included in the reimbursement for the anesthesia service. Unusual forms of monitoring (e.g., intra-arterial, central venous, and Swan-Ganz) are not included and are reimbursed separately.

Pre-operative care, post-operative care, or consultations provided by the anesthesiologist for care other than normal or uncomplicated care (e.g., pain management, may be eligible for coverage if separately identifiable services were rendered. Substantiating documentation would be required to establish that the services were not part of normal pre-or post-operative care (e.g., physician history and physical, physician progress notes, physician operative notes).

Additionally, the following procedures and services are considered as integral components of general anesthesia and are not reimbursed separately.

CPT	Description
31500	Intubation, endotracheal, emergency procedure
31505	Laryngoscopy, indirect; diagnostic (separate procedure)
31515	Laryngoscopy direct; with or without tracheoscopy, for aspiration
31527	Laryngoscopy direct; with insertion of obturator
31622	Bronchoscopy, rigid or flexible, including fluoroscopic guidance; when performed; diagnostic, with or without cell washing when performed (separate procedure)
36000	Introduction of needle or intracatheter, vein
36430	Transfusion, blood or blood components
92950	Cardiopulmonary resuscitation (e.g., in cardiac arrest)
92953	Temporary transcutaneous pacing
92960	Cardioversion, elective, electrical conversion of arrhythmia, external
93000-93010	Electrocardiogram, routine ECG with at least 12 leads
93040-93042	Rhythm ECG, one to three leads
93922	Limited bilateral noninvasive physiologic studies of upper or lower extremity arteries, (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus bidirectional, Doppler waveform recording and analysis at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus volume plethysmography at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries with, transcutaneous oxygen tension measurement at 1-2 levels)
93923	Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 or more levels (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure measurements with bidirectional doppler waveform recording and analysis, at 3 or more levels, or ankle/brachial

	indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental volume plethysmography at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis Pedis arteries plus segmental transcutaneous oxygen tension measurements at 3 or more levels), or single level study with provocative functional maneuvers (eg, measurements with postural provocative tests, or measurements with reactive hyperemia)
93924	Noninvasive physiologic studies of lower extremity arteries, at rest and following treadmill stress testing, (ie, bidirectional Doppler waveform or volume plethysmography recording and analysis at rest with ankle/brachial indices immediately after and at timed intervals following performance of a standardized protocol on a motorized treadmill plus recording of time of onset of claudication or other symptoms, maximal walking time, and time to recovery) complete bilateral study
CPT	**Description**
94002	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing; hospital inpatient/observation, initial day
94250	Expired gas collection, quantitative, single procedure (separate procedure)
94640	Pressurized or nonpressurized inhalation treatment for acute airway obstruction ofor therapeutic purposed and/or for diagnostic purposes such as sputum induction (with an aerosol generator, nebulizer, metered dose inhaler or intermittent positive pressure breathing (IPPB) device)
94680-94690	Oxygen update, expired gas analysis
94760-94762	Noninvasive ear or pulse oximetry for oxygen saturation
94770	Carbon dioxide, expired gas determination by infrared analyzer
95812-95822	Electroencephalogram (EEG)

Monitored anesthesia care (identified by the –QS modifier) is eligible for coverage when performed by the anesthesiologist, CRNA or qualified anesthetist under the medical direction of a physician, and includes all of the following criteria:

- Requested by the attending physician/operating surgeon
- Performance of a pre-anesthetic examination and evaluation
- Prescription of the anesthesia care required
- Administration of necessary oral and parenteral medications
- Personal participation in, or medical direction of, the entire plan of care
- Continuous physical presence of the anesthesiologist or, in the case of medical direction, of the qualified anesthetist) i.e., CRNA, AA) being medically directed (must be present in the operating suite during operative procedure) or proximate presence (within vicinity of the operating suite) or (in the case of medical direction) availability of the anesthesiologist for diagnosis or treatment of emergencies
- Usual non-invasive cardiovascular and respiratory monitoring
- Oxygen administration, when indicated
- Intravenous administration of sedatives, tranquilizers, anti-emetics, narcotics, other analgesics, beta-blockers, vasopressors, bronchodilators, anti-hypertensives, or other pharmacologic therapy as may be required in the judgment of the anesthesiologist.

Reimbursement for monitored anesthesia care is limited to one provider (anesthetist or anesthesiologist) per day.

Non-covered Anesthesia Services
Anesthesia services not eligible for reimbursement include, but are not limited to:

- Anesthesia by hypnosis
- Anesthesia by acupuncture
- Anesthesia for cosmetic surgery
- Standby, non-active participation for anesthesiology during surgery
- Anesthesia for investigational or non-covered surgical procedures

Positioning of the Patient
Positioning the patient (e.g., lithotomy, lateral, prone, sitting, field avoidance) before, during, or following a therapeutic procedure, is considered incidental to other services provided and not reimbursed separately.

Qualifying Circumstances for Anesthesia
Reimbursement for qualifying circumstances for anesthesia (99100-99140) is included in the basic allowance for other anesthesia procedures (00100-01999).

Local anesthesia
Local anesthesia is considered to be an integral part of the surgical procedure and no additional reimbursement is provided.

Multiple surgical procedures
When multiple surgical procedures are performed, the base value of anesthesia is the base value for the procedure with the highest relative unit value. No reimbursement is provided for the base unit values of additional procedures. Time units cover the additional time required for these procedures.

Pre-anesthesia evaluation
A pre-anesthesia evaluation by the anesthesiologist when surgery is canceled may be covered at the level of care rendered (e.g., brief or limited visit) as a hospital or office visit.

A pre-anesthesia by the anesthesiologist when the procedure is delayed is no eligible for coverage as a separate procedure. It is an integral part of the subsequent anesthesia services.

Anesthesia administered by the operating surgeon
Reimbursement for general anesthesia or intravenous analgesia administered by the operating surgeon, assistant surgeon, or obstetrician is included in the basic allowance for the surgical procedure performed.

Transesophageal Echocardiography
Transesophageal Echocardiography (TEE) placement and interpretation is no considered for separate reimbursement in addition to payment for the primary anesthesia procedure. However, when this service is performed for diagnostic purposes and documentation is provided to include a formal report, this service may be considered for separate reimbursement in accordance with CMS guidelines.

Ventilation Management
Ventilation assist and management is a covered service. This service is not necessarily confined to the critical care area. It can be rendered in a hospital setting, or in rare cases rendered in extended care facilities or the home setting. Reimbursement for initial ventilation and management is limited to one within a 30-day period. However, ventilation and management is incidental to the anesthesia service when it is performed on the same day as the anesthesia.

Epidurals
Epidural analgesia involves the administration of a narcotic drug through an epidural catheter. When performed as the primary type of anesthesia, the time required is included in the total anesthesia minutes reported.

A continuous epidural reported using procedure codes 62326 or 62327 is reimbursed only one time, as a flat rate code.

Daily hospital management of epidural or subarachnoid continuous drug administration (01996) is limited to one service per day on subsequent days. This code is reimbursed at a rate of three times the anesthesia conversion factor. There are no time units involved in the reimbursement calculation.

Labor epidurals

Anesthesia for labor epidurals are time based services and should be billed as total minutes.

> **01967:** vaginal delivery with epidural for pain management. Code may be reported as a single anesthesia service. Reimbursement is based on base units plus time units (insertion through delivery) subject to a maximum of 7 hours or 420 minutes.
>
> **01968:** cesarean delivery following failed attempt at vaginal delivery. This is an add-on code and should always be reported with 01967.
>
> **01969:** cesarean delivery followed by a cesarean hysterectomy after failed planned vaginal delivery. This is an add-on code and should always be reported with 01967.

To be reimbursed, add-on codes 01968 and 01969 must be reported with the primary code with the same date of service by the same practitioner or a different practitioner within the same group practice.

Medical Direction

Medical direction of a qualified anesthetist (CRNA) by the anesthesiologist may be covered when the anesthesiologist:

- remains physically present in the operating suite and available for immediate diagnosis and treatment of emergencies
- does not personally administer an anesthetic to another patient while medically directing
- directs not more than four (4) anesthetists performing concurrent procedures
- performs a pre-anesthetic examination and evaluation
- prescribes the anesthesia plan
- personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence
- ensures that procedures not performed by the anesthesiologists are performed by a qualified individual
- monitors the course of anesthesia administration at frequent intervals **AND**
- provides indicated post-anesthesia care

NOTE: A physician who is concurrently directing the administration of anesthesia to 1-4 patients should not typically be involved in providing services to other patients except in the following situations:

- Addressing an emergency of short duration in the immediate area
- Administering an epidural or caudal anesthetic to ease labor pain or periodic (rather than continuous) monitoring of an obstetrical patient
- Receiving patients entering the operating suite for the next surgery
- Checking or discharging patients in the recovery room
- Handling scheduling matters

If medical direction is reported by the anesthesiologist (modifier QY or QK), an anesthesia service for the same patient on the same day by a CRNA indicating no medical direction (modifier QZ) will be returned for corrected billing by the CRNA of the appropriate modifier.

Likewise, if medical direction is reported and received by a CRNA prior to the receipt of a service without medical direction, then a claim is received for an anesthesia service for the same patient on the same day by the anesthesiologist indicating medical direction is received, the claim for the medical direction will be returned pending proper modifier usage.

It would not be expected that a CRNA would report a modifier for medical direction.

Medical Supervision vs. Medical Direction
When the anesthesiologist does not fulfill all of the “medical direction” requirements listed above, the concurrent anesthesia services are considered medical supervision services and are not considered medical direction services. Reimbursement for medical supervision is included in the hospital ancillary services.

Reporting Time Units
The period of time on which anesthesia time units are based begins when the anesthesiologist is first in attendance with the patient for the purpose of induction of anesthesia, and ends when the patient leaves the operating room or delivery room. Time spent in the recovery room is included in the anesthesia base units and no additional reimbursement is provided.

Reimbursement Calculation
Anesthesia time should be submitted on the claim as total minutes. For example, 1 hour and 9 minutes of anesthesia time is billed as 69 minutes. The total minutes should be placed in field 24G of the CMS1500 claim form (or its electronic equivalent). Florida Blue then converts minutes into 15 minute increments. Florida Blue rounds the time units to the nearest tenth of a unit.

Reimbursement for Time Based Services with Anesthesia Modifiers
The following modifiers are utilized by the system to determine payment to the provider. One of these modifiers must be associated with the time based anesthesia code in order for the line to be appropriately adjudicated.

Modifier	Modifier Adjustment
AA	100%
QZ	100%
QK	50%
QX	50%
QY	50%

Anesthesia Performed by Anesthesiologist or CRNA (AA, QZ Modifier):

(Base Factor + Total Time Units) X Anesthesia Conversion Factor = Allowance

Anesthesia Performed under Medical Direction (QK, QX and QY modifiers):

[(Base Factor + Total Time Units) X Anesthesia Conversion Factor] X Modifier Adjustment .50 = Allowance for each provider

**Florida Blue utilizes the base units as defined by the America Society of Anesthesiology (ASA).

BILLING AND CODING:

CPT Codes: (if applicable)

00100-01999	Anesthesia
99100*	Anesthesia for patient of extreme age, younger than 1 year and older than 70 (List separately in addition to code for primary anesthesia procedure)
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)
99140*	Anesthesia complicated by emergency conditions (specify) (List separately in addition to code for primary anesthesia procedure
**Note: Qualifying circumstances for anesthesia is included in the basic allowance for anesthesia procedures.*	

CPT Modifiers:

47	Anesthesia by surgeon
P1	A normal healthy patient
P2	A patient with mild systemic disease
P3	A patient with severe systemic disease
P4	A patient with several systemic diseases 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 purposes
Note: Additional reimbursement is not provided for the physical status (P) modifiers	

HCPCS Codes: N/A

HCPCS Modifiers:

AA	Anesthesia services performed personally by anesthesiologist
AD	MD supervision, more than 4 anesthesia services

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

RELATED PAYMENT POLICIES:

Moderate Sedation Payment Policy, 10-010
Add-On Codes Payment Policy, 15-044

REFERENCES:

1. American Medical Association, *Current Procedural Terminology* (CPT®), Professional Edition
2. American Society of Anesthesiologists: Relative Value Guide; A Guide for Anesthesia Values (current edition)
3. Centers for Medicare and Medicaid Services (CMS) , National Correct Coding Initiative Policy Manual for Medicare Services, January 1, 2016 revision, Chapter II, *Anesthesia Services*.
4. Centers for Medicare and Medicaid Services (CMS) Medicare Claims Processing Manual, Publication 100-4, Chapter 12, Section 50 "Payment for Anesthesiology Services", pg 116-124.
5. Centers for Medicare and Medicaid Services (CMS) Transmittal 2636, "National Correct Coding Initiative (NCCI) Add-on Codes", April 1, 2013 at https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2636CP.pdf

GUIDELINE UPDATE INFORMATION:

11/15/2008	New Payment Policy
12/22/2009	Revision
05/21/2010	Revision
05/31/2012	Revision – Changed name from BCBSFL to Florida Blue
06/16/2016	Annual Review – Reimbursement Information and References sections updated
06/17/2017	Annual Review – removed expired procedure 62319; added new codes 62326 & 62327
06/14/2018	Annual Review – added "Florida Blue utilizes the base units as defined by the American Society of Anesthesiology (ASA)" under Reimbursement Information.
10/18/2018	Revision – update made to Labor Epidurals section
06/20/2019	Annual Review – CPT code descriptors revised

Private Property of Florida Blue
This payment policy is Copyright 2019, Florida Blue. All Rights Reserved. You may not copy or use this document or disclose its contents without the express written permission of Florida Blue. The medical codes referenced in this document may be proprietary and owned by others. Florida Blue makes no claim of ownership of such codes. Our use of such codes in this document is for explanation and guidance and should not be construed as a license for their use by you. Before utilizing the codes, please be sure that to the extent required, you have secured any appropriate licenses for such use. Current Procedural Terminology (CPT) is Copyright 2019 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values, or related listings are included in CPT. The AMA assumes no liability for the data contained herein. Applicable FARS/DFARS restrictions apply to government use. CPT® is a trademark of the American Medical Association.