

Procedure 1205- Anesthesia

Lines of Business: All

Purpose: This guideline describes Network Health's reimbursement of anesthesia services.

Procedure: 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), 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.

Definition

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."

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.

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

CMS defines AA and CRNA to have following qualifications:

An AA is a professional who:

- Is permitted to administer anesthesia by state law, and
- Has successfully completed a 6 year program for AAs of which 2 of the 6 years must consist of specialized academic and clinical training in anesthesia.

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 18 months and is awaiting initial certification.

Reimbursement: Anesthesia services must be reported using the appropriate anesthesia service CPT codes.

Anesthesia time 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).

To bill for anesthesia services bill the total anesthesia time expressed in minutes in item 24G on the HCFA CMS-1500 form. Network Health 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.

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.

Monitored Anesthesia Care (MAC) is a reimbursable time-based service when the appropriate monitored anesthesia modifier 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 the appropriate CPT codes.

Modifier Submission: All services reported for anesthesia delivery services must be submitted with the appropriate HCPCS modifiers to indicate how the anesthesia session was carried out:

- Anesthesia services performed personally by anesthesiologist.
- Medical supervision by a physician: more than four concurrent anesthesia procedures.
- Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure.
- Monitored anesthesia care for patient who has history of severe cardiopulmonary condition.
- Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals.
- Monitored anesthesia care service.
- Qualified nonphysician anesthetist with medical direction by a physician.
- Medical direction of one qualified nonphysician anesthetist by an anesthesiologist.
- 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 the modifier that indicates the anesthesia services were performed personally by the anesthesiologist.

Network Health will reimburse 50% of the allowable amount when anesthesia services are submitted with modifiers that indicate:

- Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals.
- Qualified nonphysician anesthetist with medical direction by a physician.
- Medical direction of one qualified nonphysician anesthetist by an anesthesiologist.

The modifier that indicates the anesthesia service has been performed in part by a resident under the direction of a teaching physician may be appended for informational purposes only in addition to a required anesthesia delivery service modifier.

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.

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 will indicate the patient is one of the following:

- A normal healthy patient
- A patient with mild systemic disease
- A patient with severe systemic disease
- A patient with severe systemic disease that is a constant threat to life
- A moribund patient who is not expected to survive without the operation
- A declared brain-dead patient whose organs are being removed for donor purposes

Qualifying Circumstances

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.

The following describes the scenarios where the services are considered add-on services:

- Anesthesia for patient of extreme age, younger than 1 year and older than 70.
- Anesthesia complicated by utilization of total body hypothermia.
- Anesthesia complicated by utilization of controlled hypotension.
- 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 the CPT service for anesthesia complicated by emergency conditions 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, Network Health 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.

Anesthesia Services

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. An injection or catheter

insertion into the epidural space or major nerve for pain management services by an anesthesia practitioner is a reimbursable service. The appropriate CPT codes 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 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. This service 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 only service provided is management of epidural/subarachnoid drug administration, then an E/M service should not be reported in addition to the management of epidural/subarachnoid drug administration. Payment for management of epidural/subarachnoid drug administration is limited to one unit of service per postoperative day regardless of the number of visits necessary to manage the catheter per postoperative day. If the anesthesiologist continues with the patient's care after discharge, the appropriate Evaluation and Management code should be used.

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. The insertion and administration of an epidural or major nerve catheter 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.

Daily hospital management of epidural or subarachnoid drug administration 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. This service 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 only service provided is management of epidural/subarachnoid drug administration, then an E/M service should not be reported in addition to the management of epidural/subarachnoid drug administration. Payment for the management of epidural/subarachnoid drug administration is limited to one unit of service per postoperative day regardless of the number of visits necessary to manage the catheter per postoperative day. If the anesthesiologist continues with the patient's care after discharge, the appropriate E/M code should be used.

Per CPT guidelines, if a physician provides the regional or general anesthesia for a surgical or medical procedure, the anesthesia by surgeon modifier should only be appended to the code for the basic medical or surgical procedure. The medical or surgical procedure appended with the anesthesia by surgeon modifier should be submitted on a single claim line.

Network Health will not reimburse for anesthesia management services when the anesthesia by surgeon modifier is reported with one of the anesthesia specific CPT codes from the Anesthesia chapter in the CPT book.

Network Health 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.

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.

Labor and Delivery Services Reimbursement: Anesthesia CPT codes and add-on codes for labor and delivery are considered reimbursable as indicated below.

The insertion and administration of an epidural 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 for vaginal delivery and anesthesia CPT codes 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 to indicate a distinct procedural service was performed.

Daily hospital management of epidural or subarachnoid drug administration 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. Daily hospital management of epidural or subarachnoid continuous drug administration 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 only service provided is management of epidural or subarachnoid drug administration, then an E/M service should not be reported in addition. Payment for management of epidural/subarachnoid drug administration is limited to one unit of service per postoperative day regardless of the number of visits necessary to manage the catheter per postoperative day. If the anesthesiologist continues with the patient's care after discharge, the appropriate E/M code should be used.

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.

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.

Insertion of an intravenous catheter for PCA 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 inserted before, during, or following a surgical procedure is a reimbursable service. An appropriate modifier would need to be appended to the procedure code to indicate that a distinct procedural service was performed.

Transesophageal Echocardiography (TEE): The following is based on ASA's guideline. Placement of the TEE probe and image acquisition and interpretation of the complex information

obtained from TEE 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.

Preoperative/Postoperative Visits: Network Health aligns with CMS by considering 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 E/M services may be submitted with an appropriate modifier 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 an appropriate modifier indicating an unrelated E/M service was rendered during a postoperative period.

This guideline 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/NHAS. NHP/NHIC/NHAS reserves the right to periodically review and update all claim guidelines, policies and procedures.

HMO plans underwritten by Network Health Plan. POS Plans underwritten by Network Health Insurance Corporation, or Network Health Insurance Corporation and Network Health Plan. Self-funded HMO and POS plans administered by Network Health Administrative Services, LLC.

Revised/approved: 01/2011; 04/2012; 11/2012; 02/2014, 10/2014; 05/2016