What You Need to Know About Anesthesia Filing Guidelines

2015 Edition

Published by Provider Relations and Education
Your Partners in Outstanding Quality, Satisfaction and Service
This document provides an outline of anesthesia filing requirements and guidelines for BlueCross BlueShield of South Carolina and BlueChoice HealthPlan of South Carolina anesthesia providers. For additional information about anesthesia, please refer to medical policy CAM 012: Anesthesia Services. You can access our medical policies online at www.SouthCarolinaBlues.com or www.BlueChoiceSC.com.

Modifiers

We require anesthesiologists and certified registered nurse anesthetists (CRNAs) to file claims using CPT anesthesia codes. We cover general anesthesia services when the operating physician requests them and a nurse anesthetist or physician, other than the operating physician, performs them for covered surgical services. We cover anesthetic or sedation procedures the operating physician performs as a part of the surgical or diagnostic procedure. We consider local anesthesia to be an integral part of the surgical procedure and provide no additional benefits. We recognize these modifiers:

Anesthesiologist Modifiers

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA</td>
<td>Anesthesia services the anesthesiologist performs personally (includes reimbursement of an employed CRNA).</td>
</tr>
<tr>
<td>AD</td>
<td>Medical supervision by a physician; more than four concurrent anesthesia procedures.</td>
</tr>
<tr>
<td>QK</td>
<td>Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals.</td>
</tr>
<tr>
<td>QY</td>
<td>Medical direction of one CRNA by an anesthesiologist.</td>
</tr>
</tbody>
</table>

CRNA Modifiers

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>QX</td>
<td>CRNA service: with medical direction by a physician.</td>
</tr>
<tr>
<td>QZ</td>
<td>CRNA service: without medical direction by a physician.</td>
</tr>
</tbody>
</table>

Monitored Anesthesia Care Modifiers

One of the current requirements is that the physician must participate in the most demanding procedures of the anesthesia plan, including induction and emergence. We may reimburse for modifiers QS, G8 and G9 if a physician personally performs the procedure (modifier AA) and if the procedure meets medical necessity criteria. We will not reimburse modifiers QK, QX, QY and QZ for supervision of monitored anesthesia care (MAC). We will not reimburse CRNAs for MAC.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>QS</td>
<td>MAC service (Must appear in the second modifier field)</td>
</tr>
<tr>
<td>G8</td>
<td>MAC for a deep complex, complicated or markedly invasive surgical procedure (Must appear in the second modifier field)</td>
</tr>
<tr>
<td>G9</td>
<td>MAC for a patient who has a history of severe cardiopulmonary condition (Must appear in the second modifier field)</td>
</tr>
</tbody>
</table>
Anesthesia Risk Factors

There are three modifiers anesthesiologists or nurse anesthetists can file indicating they have added time limits when the physical status of the patient presented a serious health risk. They must place these modifiers in the second modifier field of the claim form.

We will only pay risk factors if the physician (modifier AA on the primary anesthesia code) administers the anesthesia personally. There will be no separate reimbursement for risk factors for CRNAs or anesthesiologist supervision of CRNAs, even if they report it separately.

Risk Modifiers

**P-3** Add one time unit when a patient has a severe systemic disease, such as uncontrolled diabetes or hypertension requiring medication.

**P-4** Add two time units when a patient has a severe systemic disease that is a constant threat to life, such as severe respiratory or cardiac disease.

**P-5** Add three time units when the patient is not expected to survive for 24 hours with or without the operation, such as multiple severe trauma or severe head injury.

Other Anesthesia Information

Maternity Epidural Anesthesia

We reimburse epidural anesthesia for maternity as a global allowance with no consideration of time units. Generally, the practitioner who inserts the epidural needle will file for the total service using modifier AA. If, however, the physician and the CRNA make an arrangement to both bill for the epidural, the physician should bill either modifier QK or QY and the CRNA should bill with modifier QX.

To report obstetrical epidural administration, physicians should file code 01967 for normal delivery. If performing a cesarean section, physicians should report both codes 01967 and 01968. Physicians should not report this code for "standing-by" if the patient elects natural childbirth and the physician doesn’t perform an epidural.

Stand-by Anesthesia

We provide benefits if the anesthesiologist provides all of the personal patient care normally provided when administering anesthesia (e.g., examines patient, connects monitoring lines, personally monitors patient during operative procedure), but does not actually administer the anesthesia unless required. We may reimburse the anesthesiologist for both the procedure and time. File claims for stand-by anesthesia using the appropriate anesthesia code, anesthesia modifier and time units.
**Qualifying Circumstances**

Physicians provide many anesthesia services under particularly difficult circumstances, depending on factors such as extraordinary condition of patient, notable operative conditions and/or unusual risk factors. These circumstances significantly impact the character of the anesthesia service the physician provides.

We may only reimburse qualifying codes if the physician administers the anesthesia personally. There will be no separate reimbursement for risk factors for CRNAs or anesthesiologist supervision of CRNAs, even if providers report these separately.

If a CRNA inserts the needle under the direct supervision of an anesthesiologist, the anesthesiologist may bill a QK modifier.

**Conscious Sedation**

Physicians use sedation with or without analgesia to achieve a medically controlled state of depressed consciousness while maintaining the patient’s airway, protective reflexes and ability to respond to stimulation or verbal commands. Benefits for this service are included in the benefits we provide for medical care consultations or surgical care, including the pre- and postoperative care. We may provide reimbursement for this service if the age of the patient is less than 13 years.

**Anesthesia Units**

**Base Units**

We use the Medicare Base Units as a basis for procedures, unless specifically addressed (i.e., we will not reimburse epidurals based on Medicare Base Units).

**Time Units**

Providers should report anesthesia time units in minutes. We calculate the number of units for claims adjudication based on 15-minute increments, rounded to the nearest tenth (1/10). For example, we would calculate 49 minutes as follows:

49 minutes/15 increment = 3.266 units
3.266 would round to 3.3 time units

We do not provide anesthesia benefits for:

- The administration of anesthesia for non-covered services, such as cosmetic surgery.
- The administration of anesthesia by the attending surgeon or surgical assistant except as outlined above.
- Local anesthesia

We do not provide separate benefits for these if in conjunction with general anesthesia:

- Pre-operative anesthesia consultation
- Transesophageal cardiography
- Emergency intubation
Anesthesia Frequently Asked Questions (FAQ)

Question: Will BlueCross and BlueChoice® cover anesthesia when a physician provides it with a non-covered service?
Answer: No. When a physician provides anesthesia services with a non-covered service, we also do not cover the physician's charge for the anesthesia, with the exception of general anesthesia for dental surgical procedures that are covered under a separate dental contract.

Question: When does anesthesia time begin and end?
Answer: Anesthesia time begins when the anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room or in an equivalent area and ends when the patient may be safely placed under post-operative supervision.

Question: Do BlueCross and BlueChoice cover anesthesia when the attending or assisting physician administers it?
Answer: We do not provide benefits when the attending or assisting physician administers anesthesia, with the exception of regional anesthesia administered during delivery.

Question: Are there special processing procedures for catheters?
Answer: If a physician bills a Swan-Ganz catheter, central venous pressure (CVP) and arterial lines in conjunction with the administration of anesthesia, the reimbursement will be 50 percent of the allowance for the catheterization and/or insertion of arterial lines and 100 percent of the allowance for the administration of anesthesia. If, however, the physician bills for them without administration of anesthesia, the allowance for the Swan-Ganz catheter is 100 percent and the allowance for the CVP and arterial lines is 50 percent.