Anesthesia Services

<table>
<thead>
<tr>
<th>Type:</th>
<th>Policy Specific Section:</th>
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<tbody>
<tr>
<td>Payment Policy</td>
<td>Payment</td>
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</table>

Original Policy Date: October 1, 2010

Effective Date: March 30, 2012

Definitions of Decision Determinations

**Medically Necessary:** A treatment, procedure or drug is medically necessary only when it has been established as safe and effective for the particular symptoms or diagnosis, is not investigational or experimental, is not being provided primarily for the convenience of the patient or the provider, and is provided at the most appropriate level to treat the condition.

**Investigational/Experimental:** A treatment, procedure or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

**Split Evaluation:** Blue Shield policy review can result in a Split Evaluation, where a treatment, procedure or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

Description

Anesthesia services consist of the administration of an anesthetic agent in one of the following types of anesthesia:

- General anesthesia: loss of ability to perceive pain associated with loss of consciousness produced by intravenous infusion of drugs or inhalation of anesthetic agents
Regional anesthesia: use of local anesthetic solution(s) to produce circumscribed areas of loss of sensation. This includes nerve blocks, spinal, epidural, and field blocks. Local infiltration or topical application of an anesthetic into or onto the operative site is local, rather than regional anesthesia.

This payment policy only addresses anesthesia reimbursement. This policy does not address medical necessity. Medical necessity must first be met, when a medical policy exists.

Policy

The American Society of Anesthesiology (ASA) guidelines and the Centers for Medicare and Medicaid Services (CMS) are used as a foundation for developing Blue Shield of California’s policies and valuing anesthesia services. All anesthesia values are determined by adding a Base unit, which is related to the complexity of the services, plus Modifying units (if any), plus Physical Status, plus Qualifying Circumstances, plus Time units, multiplied by the regional conversion factor (CF). Time units are calculated at one unit per 15 minutes. Actual anesthesia time should be reported in minutes.

Base unit + Modifying units (if any) + Physical Status (if any) + Qualifying Circumstances (if any) + Time unit x CF = Anesthesia Reimbursement

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 the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under postoperative supervision. Time spent in the recovery room is included in the anesthesia base units and no additional benefits are provided.

The reporting of anesthesia services is appropriate by or under the supervision of a physician. These services may include, but are not limited to, the following:

- General anesthesia
- Regional anesthesia
- Other supportive services in order to afford the patient the anesthesia care deemed optimal by the anesthesiologist during any procedure
- Usual preoperative and postoperative visits
- Anesthesia care during the procedure
- Administration of fluids and/or blood
- Usual monitoring services (such as electrocardiogram, temperature, blood pressure, oximetry, capnography and mass spectrometry)

Unusual forms of monitoring, such as intra-arterial, central venous and Swan-Ganz catheters, are not included in the anesthesia procedure, may be listed separately and are separately reimbursable. The following codes may apply:

- CPT code 36555: Insertion of non-tunneled central venous catheter, less than five years of age
• CPT code 36556: Insertion of non-tunneled central venous catheter, older than five years of age
• CPT code 36620: Arterial catheterization
• CPT code 36625: Arterial catheterization, cutdown
• CPT code 93503: Insertion of Swan-Ganz catheter

Transesophageal echocardiography (TEE) monitoring is separately reimbursable if placed for guidance in surgical interventions (e.g., myocardial revascularization, valvular competence and repair of congenital heart defects) and to guide pharmacological support and/or fluid administration in the perioperative time. These codes are not billed in units. The following codes apply:

• CPT code 93312: TEE, with image documentation
• CPT code 93313: TEE, placement of transesophageal probe only
• CPT code 93314: TEE, image acquisition
• CPT code 93315: TEE, for congenital cardiac anomalies
• CPT code 93316: TEE, placement of transesophageal probe only
• CPT code 93317: TEE, image acquisition
• CPT code 93318: TEE, for monitoring purposes

Physical Status Modifiers

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>Units</th>
</tr>
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<tbody>
<tr>
<td>P1</td>
<td>A normal healthy patient</td>
<td>None</td>
</tr>
<tr>
<td>P2</td>
<td>A patient with mild systemic disease</td>
<td>None</td>
</tr>
<tr>
<td>P3</td>
<td>A patient with severe systemic disease</td>
<td>One</td>
</tr>
<tr>
<td>P4</td>
<td>A patient with severe systemic disease that is a constant threat to life</td>
<td>Two</td>
</tr>
<tr>
<td>P5</td>
<td>A moribund patient who is not expected to survive without the operation</td>
<td>Three</td>
</tr>
<tr>
<td>P6</td>
<td>A declared brain-dead patient whose organs are being removed for donor purposes</td>
<td>None</td>
</tr>
</tbody>
</table>
Qualifying circumstances for anesthesia

Qualifying circumstances for anesthesia, when allowable, is reimbursed at a statewide flat rate fee schedule with a one-unit maximum allowable. These circumstances should not be reported alone but reported as additional procedure numbers (add-ons) qualifying as anesthesia procedure or service. The following procedure codes apply:

- CPT code 99100: Anesthesia for patient of extreme age, younger than one year or older than 70
- CPT code 99116: Anesthesia complicated by utilization of total body hypothermia
- CPT code 99135: Anesthesia complicated by utilization of controlled hypotension
- CPT code 99140: Anesthesia complicated by emergency conditions (specify)


The following apply:

- Modifier -23: Unusual anesthesia
- Modifier -59: Distinct Procedural Services
- Modifier -73: Discontinued outpatient hospital/ambulatory surgical center procedure prior to the administration of anesthesia. Reimbursement will be for one unit only.

Certified Registered Nurse Anesthetists

Payment for certified registered nurse anesthetists (CRNA) services, when allowable, is reimbursable at 65% of anesthesia reimbursement.

Epidural or Subarachnoid Catheters

Payment for the routine daily management of epidural or subarachnoid drug administration, when allowable, is reimbursable at a statewide daily rate. In addition, reimbursement is once daily subsequent to the date of surgery and is subject to a maximum cap of three days.

The following code applies:

- CPT code 01996: Daily hospital management of epidural or subarachnoid catheter

Local Anesthesia

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

Moderate Sedation Services

Refer to Payment Policy first to determine medical necessity.

Payment for moderate sedation services, when allowable, is reimbursable at a statewide fee schedule.

- CPT code 99143: Moderate Sedation Services (MSS), by the same physician, younger than five years of age, first 30 minutes
- CPT code 99144: MSS, age five years of age or older, first 30 minutes
- CPT code 99145: MSS, each additional 15 minutes
CPT code 99148: MSS, by another physician, younger than five years of age, first 30 minutes
CPT code 99149: MSS, age five years of age or older
CPT code 99150: MSS, each additional 15 minutes

Nerve blocks (nerve, spinal and field blocks)

Refer to Medical Policy first to determine medical necessity.

Payment for nerve blocks, when allowable, and administered alone or in conjunction with general anesthesia services, is reimbursable at established professional fee schedule amounts, subject to the following:

- The time spent on pre- or postoperative placement of the block is separate and clearly not included in the reported/billed general anesthesia time when the nerve block is being performed on the same day of service as general anesthesia services
- The nerve block is billed with modifier -59 to verify that it is a distinct procedural service as indicated above, when general anesthesia services are also provided on the same day of service
- Anesthesia base and time units are not applicable for nerve blocks. Nerve blocks are reimbursable in accordance with Blue Shield of California's established professional fee schedule amounts. This is applicable for nerve blocks administered alone or in conjunction with (on the same day) general anesthesia services
- When the nerve block is billed alone, it should be billed under the appropriate injection/block code
- For most nerve blocks, image guidance is not usually required. Separate imaging charges are subject to medical necessity review

The following codes apply:

- CPT code 62310: Injection, single, epidural or subarachnoid; cervical or thoracic
- CPT code 62311: lumbar, sacral
- CPT code 62318: Injection, continuous infusion, epidural or subarachnoid; cervical or thoracic
- CPT code 62319: lumbar, sacral
- CPT code 64400: Injection; trigeminal nerve, any branch
- CPT code 64402: facial nerve
- CPT code 64405: greater occipital nerve
- CPT code 64408: vagus nerve
- CPT code 64410: phrenic nerve
- CPT code 64412: spinal accessory nerve
- CPT code 64413: cervical plexus
- CPT code 64415: brachial plexus, single
- CPT code 64416: brachial plexus, continuous infusion
- CPT code 64417: axillary nerve
- CPT code 64418: suprascapular nerve
• CPT code 64420: intercostal nerve, single
• CPT code 64421: intercostal nerve, multiple, regional block
• CPT code 64425: ilioinguinal, iliohypogastric nerves
• CPT code 64430: pudendal nerves
• CPT code 64435: paracervical (uterine) nerve
• CPT code 64445: sciatic nerve, single
• CPT code 64446: sciatic nerve, continuous infusion
• CPT code 64447: femoral nerve, single
• CPT code 64448: femoral nerve, continuous infusion
• CPT code 64449: lumbar plexus, continuous infusion
• CPT code 64450: other peripheral nerve or branch
• CPT code 64455: Injection, anesthetic agent and/or steroid, plantar common digital nerve
• CPT code 64479: transforaminal epidural: cervical or thoracic, single level
• CPT code 64480: cervical or thoracic, each additional level
• CPT code 64483: lumbar or sacral, single level
• CPT code 64484: lumbar or sacral, each additional level
• CPT code 64490: Injection, paravertebral facet joint with image guidance
• CPT code 64491: second level
• CPT code 64492: third and any additional levels
• CPT code 64493: Injection, paravertebral facet joint with image guidance, lumbar or sacral, single level
• CPT code 64494: second level
• CPT code 64495: third and any additional levels
• CPT code 64505: Injection, sphenopalatine ganglion
• CPT code 64508: carotid sinus (separate procedure)
• CPT code 64510: stellate ganglion
• CPT code 64517: superior hypogastric plexus
• CPT code 64520: lumbar or thoracic
• CPT code 64530: celiac plexus, with or without radiologic monitoring

Obstetrical Anesthesia

Payment for obstetric anesthesia, when allowable, is reimbursable as the Base unit, plus Time units, plus Modifier units, subject to a maximum cap of 23 units. The following codes apply:

• CPT code 01960: Anesthesia for vaginal delivery (Report only when the patient has not received any labor analgesia/anesthesia care)
• CPT code 01961: Anesthesia for cesarean delivery (Report only when the patient has not received any labor analgesia/anesthesia care)
• CPT code 01967: Neuraxial labor analgesia/anesthesia
• CPT code 01968: Anesthesia for cesarean following neuraxial

Percutaneous Image Guided Procedure

Refer to Medical Policy first to determine medical necessity.
Payment for percutaneous image guided procedures, when allowable, is reimbursable at a statewide flat rate fee schedule.

The following codes apply:

- CPT code 01935: Anesthesia for percutaneous image guided procedure, diagnostic
- CPT code 01936: therapeutic

**Spinal manipulation under anesthesia**

Refer to Medical Policy first to determine medical necessity.

The following codes apply:

- CPT code 00640: Anesthesia for closed manipulation
- CPT code 22505: Manipulation of spine requiring anesthesia

**Policy Guideline**

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 evaluation** by the anesthesiologist when the procedure is delayed is not eligible for coverage as a separate procedure. It is an integral part of the subsequent anesthesia services.

If anesthesiologists are in a **group practice**, one physician member may provide the pre-anesthesia examination and evaluation while another fulfills the other criteria. Similarly, one physician member of the group may provide post-anesthesia care while another member of the group furnishes the other component parts of the anesthesia service. The medical record must indicate the services furnished and identify the physicians who furnished them. However, only one member of the group is eligible to bill for the entire anesthesia service.

If an **organ or tissue transplant** is eligible for payment, the anesthesia services for harvesting the organ or tissue from a cadaver donor is also covered (maintaining respiration, oxygenation, etc.). Harvesting or organs or tissue requires careful maintenance of the donors to retain organ viability. However, base relative value and time units are only allowed, with no additional modifying units.

**Supervision by an anesthesiologist of a nurse anesthetist** or a physician-in-training is limited to no more than four procedures performed concurrently. An anesthesiologist having such an obligation should not actually be administering anesthesia.

**Standby anesthesia services** are not eligible for coverage even when required by the facility in which the patient is to have surgery.

When **multiple surgical procedures** are performed during a single anesthetic administration, the anesthesia code representing the most complex procedure should be reported. The time reported is the combined total for all procedures.
If circumstances warrant two anesthesiologists, documentation should be submitted with the claim. A base value of five units plus time will be allowed for the second anesthesiologist.

### Documentation Required for Clinical Review

<table>
<thead>
<tr>
<th>Post Service</th>
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<tbody>
<tr>
<td>• Anesthesia report, if applicable</td>
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</tbody>
</table>

The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract. These Policies are subject to change as new information becomes available.