Important Information

The following disclaimer is applicable to all telephone inquiries and automated communications systems (i.e., telephone and fax) to Blue Cross and Blue Shield of Alabama:

The information provided is only general benefit information and is not a guarantee of payment. Benefits are always subject to the terms and limitations of the plan and are at the discretion of Blue Cross and Blue Shield of Alabama. Authority to enlarge or expand the terms of the plan is within the discretion of Blue Cross and Blue Shield of Alabama. The availability of benefits is always conditioned upon the existence of a contract for plan benefits as of the date of service. Loss of coverage, as well as contract termination, can occur under certain circumstances. There will be no benefits available if such circumstances occur.

Note: Please refer to our website, AlabamaBlue.com/providers, for the most current benefit and policy information.

CPT codes, descriptions, and other data only are copyrighted © 2015 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
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A. General Services

Blue Cross and Blue Shield of Alabama recognizes and covers medically necessary anesthesia services when performed by a qualified and licensed medical doctor (MD), certified registered nurse anesthetist (CRNA) or anesthesiologist assistant (AA) as defined by a member’s specific benefit contract.

Global Services
Global reimbursement of anesthesia administration includes the following:

- Post-postoperative visits (CPT codes 99211-99215, 99231-99233);
- Anesthetic or analgesic administration;
- Local anesthesia during surgery;
- Monitoring of electrocardiograms (EKGs), pulse breathing, blood pressure, electroencephalogram and other neurological monitoring;
- Monitoring of left ventricular or valve function via transesophageal echocardiogram (TEE);
- Monitoring of intravascular fluids (IVs), blood administration and fluids used during cold cardioplegia through non-invasive means; and
- Maintenance of open airway and ventilator measurements and monitoring.

Arterial lines and monitoring are no longer included in the global anesthesia fee. Bill for these services separately using the same major/minor guidelines that are used with surgical services, when billed with other procedures such as Swan Ganz.

Use of TEE for routine monitoring of patients undergoing cardiac and non-cardiac surgery does not meet Blue Cross’ medical criteria for coverage. See Medical Policy #269: Intraoperative Transesophageal Echocardiography for additional details and covered indications.

According to CPT guidelines, the reporting of anesthesia services is appropriate by or under the responsible supervision of a physician. These services may include, but are not limited to, general, regional and supplementation of local anesthesia or other supportive services in order to provide the patient with optimal anesthesia care during any procedure.

Covered Services
Anesthesia services may be covered only when:
- The procedure for which anesthesia is administered is a covered service under the member’s applicable Benefit Agreement; and
- Consultations rendered by an anesthesiologist for care, other than normal or uncomplicated care, may be eligible for coverage if separately identifiable services were rendered. Substantiating documentation is required for medical review of medical necessity. See Medical Policy #129: Consultations vs. Referrals in the Provider Manual.
Non-Covered Services
Services not covered under the terms of the member’s applicable Benefit Agreement include, but are not limited to, the following:

• Standby anesthesia – Blue Cross does not cover physicians “standing by” in anticipation of needing general anesthesia;
• Anesthesia administered by the operating physician or surgical resident;
• Anesthesia by hypnosis or acupuncture; and/or
• Anesthesia for cosmetic surgery.

Administration of Anesthesia by Operating Physician
No additional payment will be made to an operating physician for anesthesia services rendered during the course of performing a surgical procedure. Under the global guidelines, payment made to a surgeon includes payment for anesthesia administered by the operating surgeon.

Consultations
Anesthesia consultation is part of the global procedure when performed on the day of or before the procedure and is not separately billable. However, there are some circumstances when a consultation is payable:

• Anesthesiologist consults with the patient for management of chronic intractable pain; and
• Anesthesiologist performs the consultation, but no anesthesia procedure is performed. For example, time is spent in discussion with a patient, but the patient was not induced due to complications.

Documentation Requirements
All billing must be supported by the patient’s anesthesia record.

B. Medical Direction, Supervision and Personally Performed

Medical Direction
Medical direction occurs when an anesthesiologist is involved in two, three or four concurrent anesthesia procedures or a single anesthesia procedure with a qualified anesthetist. Payment will be determined for the physician's medical direction service of the allowable charge for the physician personally performing the anesthesia services. For each anesthesia procedure, the anesthesiologist must provide the following seven services and record each in the patient’s anesthesia record:

1. A pre-anesthetic examination and evaluation;
2. Prescribe the anesthesia plan;
3. Personally participate in the most demanding procedures of the anesthesia plan including, if applicable, induction and emergence;
4. Ensure that any procedure in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist;
5. Monitor the course of anesthesia administration at frequent intervals;
6. Remain immediately physically present and available for immediate diagnosis and treatment of emergencies; and
7. Provide the indicated post-anesthesia care.
If the above services are not performed by the anesthesiologist, the service is not considered medical direction. The anesthesiologist must document in the patient’s medical record that he or she performed the pre-anesthesia examination and evaluation. The record should also document that the anesthesiologist provided post-anesthesia and whether the anesthesiologist was present during some portion of the anesthesia monitoring or during the most demanding procedures, including induction and emergence, where applicable.

When the anesthesiologist does not fulfill all of the “medical direction” requirements listed above, the concurrent anesthesia services are considered medical supervision services, not medical direction services.

- When an anesthesiologist is supervising more than four concurrent cases, the service should be filed as follows: anesthesiologist – “AD” and CRNA – “QX”
- When a CRNA personally performed the services without medical direction or supervision, as described above, the service should be filed as follows: CRNA – “QZ”
- AAs are always under the “medical direction” of an anesthesiologist

Ordinarily, anesthesiologists should not furnish additional services to other patients while concurrently directing the administration of anesthesia. Benefits may be provided if the anesthesiologist provides any of the following services to other patients while medically directing the administration of anesthesia without affecting their ability to administer medical direction:

- Addressing an emergency of short duration in the immediate area, such as:
  1. Labor epidural placement and management;
  2. Responding to medical emergencies or urgencies of short duration (i.e., establishing intravascular access in patient whose quality of care is reduced without it, tracheal intubation, advanced circulatory life support (ACLS) provision, etc.);
- Administering an epidural or caudal anesthetic to ease labor pain;
- Administering an epidural steroid injection or trigger point injection requested by another physician. The epidural or trigger point injection may only be done in compliance with the 1:4 ratio. This does not include consults to diagnose and treat. The intent of allowing this practice is enhancement of efficiency in providing these commonly requested procedures. The intent is not to allow or encourage anesthesiologists to schedule and provide a full service chronic pain management clinic while also concurrently attempting to provide the care to patients receiving surgical anesthesia under his or her direction. The consult for performance of an epidural or trigger point may serve as the second, third, or fourth concurrent case. This means that performing limited pain services is not allowed while medically directing four concurrent anesthetics. The anesthesiologist involved is responsible for being sure his or her ability to respond to urgent or emergent needs in operating rooms, labor and delivery rooms, or any other place in the hospital where responsibility may be, is not unsafely reduced at any time;
- Periodic rather than continuous monitoring of an obstetrical patient;
- Receiving patients entering the operating suite for the next surgery;
- Checking on or discharging patients from the post anesthesia care unit; and/or
- Coordinating scheduling matters.
Medical Supervision
Medical supervision also occurs when the seven required services under medical direction are not performed by an anesthesiologist. This might occur in cases when the anesthesiologist:
• Left the immediate area of the operating suite for more than a short duration;
• Devoted extensive time to an emergency case; or
• Was otherwise not available to respond to the immediate needs of the surgical patient.

Personally Performed Anesthesia
Determined by the following:
• Anesthesiologist personally performed the entire anesthesia service alone;
• Anesthesiologist is continuously involved in a single case involving a student nurse anesthetist; or
• Anesthesiologist and the CRNA are involved in one anesthesia case, and the service of each are found to be medically necessary upon appeal. Documentation must be submitted by both practitioners to support payment;
• CRNA personally performed the entire anesthesia service alone without:
  1. Medical direction by anesthesiologist, and;
  2. Not medically supervised by an anesthesiologist.

A CPT/Healthcare Common Procedure Coding System (HCPCS) modifier is a two-character (alpha and/or numeric) code appended to a CPT/HCPCS procedure code to add specific meaning to a service provided. Blue Cross requires the use of the following HCPCS Level II modifiers when filing general anesthesia claims. Effective for dates of service on or after January 1, 2014, failure to submit one of the the modifiers in the first position will result in returned or denied claims.

Required Modifiers used by Anesthesiologists include:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>% of Allowed Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA</td>
<td>Anesthesia services performed personally by the anesthesiologist</td>
<td>100 percent</td>
</tr>
<tr>
<td>AD</td>
<td>Medical supervision by a physician; more than four concurrent anesthesia procedures. (Three base units + actual time units allowed)</td>
<td>65 percent</td>
</tr>
<tr>
<td>QK</td>
<td>Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals.</td>
<td>65 percent</td>
</tr>
<tr>
<td>QY</td>
<td>Medical direction of one CRNA/AA by an anesthesiologist</td>
<td>65 percent</td>
</tr>
</tbody>
</table>
Physical Status Modifiers
Physical status modifiers distinguish between various levels of complexity of the anesthesia service provided based on the patient’s condition and are represented by the letter P followed by a single digit. These modifiers are required for Monitored Anesthesia Care (MAC).

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>Normal healthy patient</td>
</tr>
<tr>
<td>P2</td>
<td>Patient with mild systemic disease</td>
</tr>
<tr>
<td>P3</td>
<td>Patient with severe systemic disease</td>
</tr>
<tr>
<td>P4</td>
<td>Patient with severe systemic disease that is a constant threat to life</td>
</tr>
<tr>
<td>P5</td>
<td>Moribund patient who is not expected to survive without the operation</td>
</tr>
<tr>
<td>P6</td>
<td>Declared brain-dead patient whose organs are being removed for donor purposes</td>
</tr>
</tbody>
</table>

Note: Effective for dates of service on or after January 1, 2014, physical status modifiers do not impact reimbursement rates. No additional units will be added for physical status.

Qualifying Circumstances
Qualifying circumstances are those factors such as extreme age, extraordinary condition of the patient, and unusual risk factors which may affect the anesthesia services. These procedures are considered add-on codes and would not be reported alone, but as additional procedures qualifying an anesthesia procedure or service. These procedures must be filed with the appropriate modifier. Codes without the appropriate modifier may be returned or rejected. Do not bill these procedures with physical status modifiers or anesthesia minutes. An additional fee will be reimbursed based on the allowed units for each circumstance:

99100 – Anesthesia for Patient of Extreme Age, Under 1 Year and Over 70 – 1 unit
99116 – Anesthesia Complicated By Utilization of Total Body Hypothermia – 5 units
99135 – Anesthesia Complicated By Utilization of Controlled Hypotension – 5 units
99140 – Anesthesia Complicated – 1 unit

Required Modifiers used by CRNAs and AAs include:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
<th>% of Allowed Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>QX</td>
<td>CRNA/AA service with medical direction by an anesthesiologist.</td>
<td>35 percent</td>
</tr>
<tr>
<td>QZ</td>
<td>CRNA service without medical direction by an anesthesiologist.</td>
<td>70 percent</td>
</tr>
</tbody>
</table>

Note: Modifiers are also required for add-on codes 01953, and 01968-01969.
### Additional Anesthesia Modifiers

The following modifiers should be used as secondary or tertiary modifiers only and not as the primary modifier. These modifiers are intended to provide additional information specific to the services provided; there will be no additional reimbursement made for these modifiers.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>Increased Procedural Service — Per CPT Appendix A modifiers: When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, and severity of patient’s condition, physical and mental effort required). Note: This modifier should not be appended to an Evaluation and Management (E/M) service.</td>
</tr>
<tr>
<td>23</td>
<td>Unusual Anesthesia — Occasionally, a procedure which usually requires either no anesthesia or local anesthesia must be done under general anesthesia because of unusual circumstances. Unusual circumstances may be reported by adding the modifier “23” to the procedure code of the basic service.</td>
</tr>
<tr>
<td>47</td>
<td>Anesthesia by Surgeon: Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service (this does not include local anesthesia). Note: modifier 47 would not be used as a modifier for anesthesia procedures.</td>
</tr>
<tr>
<td>53</td>
<td>Discontinued Procedure — Under certain circumstances, the physician or other qualified healthcare professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the wellbeing of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the individual for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient’s anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the wellbeing of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).</td>
</tr>
<tr>
<td>Modifier</td>
<td>Description</td>
</tr>
<tr>
<td>----------</td>
<td>-------------</td>
</tr>
<tr>
<td>59</td>
<td>Distinct Procedural Service — Services with modifier 59 may be subject to review of medical records. Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Modifier 25 should be used only if a more descriptive modifier is not available, and the use of modifier 59 best explains the circumstances. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25.</td>
</tr>
<tr>
<td>73</td>
<td>Discontinued Outpatient Hospital/ASC procedure prior to the administration of anesthesia — Due to extenuating circumstances or those that threaten the wellbeing of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient’s surgical preparation (including sedation when provided, and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia [local, regional block(s) or general]. Under these circumstances, the intended service that is prepared for but cancelled can be reported by its usual procedure code and the addition of modifier 73. Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.</td>
</tr>
<tr>
<td>74</td>
<td>Discontinued Outpatient Hospital/ASC procedure after the administration of anesthesia — Due to extenuating circumstances or those that threaten the wellbeing of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia [local, regional block(s), general] or after the procedure was started (incision made, intubation started, scope inserted, etc.). Under these circumstances, the procedure started but terminated can be reported by its usual procedure code and the addition of modifier 74. Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier 53.</td>
</tr>
</tbody>
</table>
C. Billing Requirements

Claim Filing
Effective for dates of service on or after January 1, 2014, Blue Cross requires claims for anesthesiologists, CRNAs and AAs to be billed under the name and National Provider Identifier (NPI) of the provider who actually rendered the service. Blue Cross does not recognize “incident to” billing for anesthesia services. All providers should render services based on the scope of their particular license and requirements of the State of Alabama. Practitioners (anesthesiologists, CRNAs and AAs) must each file for the professional anesthesia services they performed electronically on the electronic 837 Professional 5010.

For CRNA services performed on or after January 1, 2014, services will no longer be reimbursed through the hospital Blue Cross Cost Study. Both CRNA costs and charges should be excluded from the costs and charges reported in the hospital Blue Cross Cost Study.

Coding
Qualified anesthesia providers may bill directly for services using CPT anesthesiology codes 00100 – 01999. While some surgical CPT codes are appropriate to use when billing anesthesia services (e.g., CPT code 36620) the majority of anesthesia services should be billed using codes in the range of 00100 – 01999.

Base Units
The base unit is the value assigned to each CPT code and includes all usual services except the time actually spent in anesthesia care. Pre-operative and post-operative visits are usually included. When multiple anesthesia services are performed, only the anesthesia services with the highest base unit value should be filed with total time for all services reported on the highest base unit value. The base units value should never be entered in the “units” field when filing claims. Effective for dates of service on or after January 1, 2014, Blue Cross will utilize the Centers for Medicare & Medicaid Services (CMS) base unit values.

Anesthesia Time and Calculation of Time Units
According to CPT guidelines, anesthesia time begins when the anesthetists begins to prepare the patient in the operating room or in an equivalent area and ends when the anesthetist is no longer in personal attendance and the patient may be safely placed under post-anesthetic supervision.

Anesthesia time should be reported in minutes. Effective for dates of service on or after January 1, 2014, for all Anesthesiologists, CRNAs and AAs, one unit of time will be allowed for each 15 minute increment of anesthesia or a fraction thereof.

Reimbursement for time based anesthesia is based on the following formulas:

Anesthesia Personally Performed by Anesthesiologist or CRNA (AA or QZ Modifier)

\[(\text{Base Factor} + \text{Total Time Units}) \times \text{Anesthesia Conversion Factor} \times \text{Modifier Adjustment} = \text{Allowance}\]

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

\[\left(\left(\text{Base Factor} + \text{Total Time Units}\right) \times \text{Anesthesia Conversion Factor}\right) \times \text{Modifier Adjustment} = \text{Allowance for each provider}\]
Anesthesia “base unit” is the number of units assigned for the anesthetic management of surgical procedures using nationally recognized anesthesia base value standards. Base units are automatically calculated and should not be reported on the claim form. Blue Cross will utilize the CMS base unit values.

Anesthesia time should be submitted on the claim as total minutes. For example, one hour and nine minutes of anesthesia time is billed as 69 minutes. Blue Cross then converts minutes into 15-minute increments. This calculation would be four 15 minute time units and 9/15 of one unit. Total time units for this example are 4.6.

Blue Cross recognizes that the patient must be prepared immediately prior to induction and that some time may be spent immediately after the conclusion of the surgical procedure. Generally, no more than one unit should be necessary to prepare the patient for post-operative transfer to the recovery room. It is inappropriate to bill for anesthesia time while the patient is waiting in a holding area. If it is necessary for a more extensive service to be provided, documentation must be provided in the patient’s medical record to substantiate medical necessity. It is inappropriate to bill time units for services such as administration of blood products or antibiotics in the holding area, when such services could be provided in another area of the hospital or facility.

Billing Modifier Combinations

Claims for anesthesia services, must be filed using a modifier on each line of the claim. The modifiers are specific to the provider’s specialty. Claims filed by an anesthesiologist that contains a QX or QZ modifier on any claim line will be returned to the provider or denied. Likewise, a claim filed by a CRNA that contains AA, AD, QY or QK modifiers in any position will be returned to the provider or denied. A claim filed by an AA may only use a QX modifier and if any other modifier appears in any position on any line, the claim will be returned to the provider or denied. The following chart reflects the appropriate modifier, by specialty, that should be in the first position on each line of claim filed by the provider.

Non-Acceptable Modifier Combinations:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Deny claim when filed on the same claim line with:</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA – Anesthesiologists</td>
<td>AD, QY, QK, QX, or QZ</td>
</tr>
<tr>
<td>QY – Anesthesiologists</td>
<td>AA, AD, QK, QX, or QZ</td>
</tr>
<tr>
<td>QK – Anesthesiologists</td>
<td>AA, AD, QY, QX, or QZ</td>
</tr>
<tr>
<td>AD – Anesthesiologists</td>
<td>AA, QY, QK, QX, or QZ</td>
</tr>
<tr>
<td>QX – CRNAs/AAs</td>
<td>AA, AD, QY, QK, or QZ</td>
</tr>
<tr>
<td>QZ – CRNAs</td>
<td>AA, AD, QY, QK, or QX</td>
</tr>
</tbody>
</table>
Cancelled Anesthesia
If anesthesia is cancelled due to unforeseen circumstances; the pre-anesthetic examination and the anesthesia services furnished may be billed and paid depending on when the anesthesia services were terminated and whether or not the procedure is rescheduled.

- If a case was cancelled after the pre-operative examination but prior to the patient being prepared for surgery or induction, the service may be covered at the E/M 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 less than 30-days is not eligible for coverage as a separate procedure. It is an integral part of the subsequent anesthesia services.
- If a case was cancelled after induction of anesthesia, bill the case with the anesthesia CPT code for the procedure that was being rendered. Add a “53” for the tertiary modifier to indicate the discontinued procedure. Reimbursement will be based on the amount of time reported plus the base units for the discontinued procedure.

Multiple or Duplicate Anesthesia Services
When multiple surgical procedures are performed during a single anesthesia administration, only the anesthesia with the highest base value is reported. Reported time is the combined total for all procedures.

When duplicate anesthesia codes are reported by the same or different provider for the same patient on the same date of service, specific reimbursement will be based on the reported modifier. File with appropriate modifiers.
## D. Additional Anesthesia Reimbursement

<table>
<thead>
<tr>
<th>Local Anesthesia</th>
<th>Reimbursement for topical anesthesia, local anesthesia, local infiltration and/or metacarpal/digital block, is included in the basic allowance of the surgical procedure performed. No additional reimbursement is provided.</th>
</tr>
</thead>
</table>
| **Anesthesia During Delivery** | **Labor Epidurals**  
Anesthesia for labor epidurals are time-based services and should be billed as total minutes.  
CPT code 01967: Neuraxial Labor Analgesia/Anesthesia for Planned Vaginal Delivery  
This includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor.)  
Code may be reported as a single anesthesia service.  
CPT code 01968: Cesarean delivery following failed attempt at vaginal delivery  
This is an add-on code and should always be reported with CPT code 01967.  
CPT code 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 CPT code 01967.  
CPT code 99140: This add-on code may be billed for labor ending in an urgent or emergency cesarean delivery with four additional units.  
Note: 01967 and add-on codes 01968 and 01969 require a concurrency modifier in the first position.  
Scenarios:  
• For labor less than 4 hours ending in vaginal delivery: CPT code 01967  
• For labor less than 4 hours ending in a cesarean delivery: CPT code 01967 and 01968  
• For labor ending in an urgent or emergency cesarean delivery, CPT code 99140 may be billed with CPT code 01967 and 01968  
• For labor 4 hours or more ending in a vaginal delivery: CPT code 01967 with modifier 23  
• For labor 4 hours or more ending in a cesarean delivery: CPT code 01967 with modifier 23 and add on CPT code 01968  
• For labor ending in an urgent or emergency cesarean delivery: CPT code 01967 with add-on code 01968 and 99140  
Note: Payment for anesthesia administered by the delivering physician is included in the global maternity fee. |
<table>
<thead>
<tr>
<th><strong>Anesthesia for Burns</strong></th>
<th>CPT code 01952 is the primary code for billing Anesthesia for Second and Third Degree Burn Excision or Debridement With or Without Skin Grafting. The add-on CPT code 01953 is not considered an anesthesia management service and should not be reported with time. CPT code 01953 may be reported with units of service up to a maximum of 10. This procedure will be paid from the fee schedule rather than the anesthesia calculation with time and base units. CPT code 01952 and add-on code 01953 must be filed with the appropriate modifier in the first position.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nerve Blocks</strong></td>
<td>When introduction or injection of anesthetic agent is administered the anesthetic agent is included in the payment for the actual procedure and not separately billable.</td>
</tr>
<tr>
<td><strong>Epidural Catheters</strong></td>
<td>For control of intractable pain that is resistant to conventional forms of therapy (i.e., physical therapy, TENS units, etc.) payment may be allowed for the placement of a catheter. In addition, CPT code 01996 (daily management) may be billed on a daily basis as long as an identifiable service is being rendered by the anesthesiologist, CRNA or AA and deemed medically necessary and within the scope of their license. CPT code 01996 is not allowed on the same day as placement of an epidural catheter.</td>
</tr>
<tr>
<td><strong>Intractable Pain</strong></td>
<td>These services are covered separately when performed for the control of post-operative pain and billed by an anesthesiologist, CRNA or AA within the scope of their license. Otherwise, these services are included in the global surgery or other medical service. The usual route of administration via a PCA pump is through an intravenous line. When this service is provided through an intravenous line, an anesthesiologist will be allowed four additional units for providing management of the PCA pump. The global reimbursement covers any rate or dosage adjustments necessary during the post-operative period. Use CPT code 01999 to report this service.</td>
</tr>
<tr>
<td><strong>Patient Controlled Analgesia (PCA)</strong></td>
<td>These services are covered separately when performed for the control of post-operative pain and billed by an anesthesiologist, CRNA or AA within the scope of their license. Otherwise, these services are included in the global surgery or other medical service. The usual route of administration via a PCA pump is through an intravenous line. When this service is provided through an intravenous line, an anesthesiologist will be allowed four additional units for providing management of the PCA pump. The global reimbursement covers any rate or dosage adjustments necessary during the post-operative period. Use CPT code 01999 to report this service.</td>
</tr>
</tbody>
</table>
| **Anesthesia for CAT Scans and MRI Procedures** | Payment can be made for anesthesia for computerized axial tomography (CAT) or magnetic resonance imaging (MRI) scans by Blue Cross if there is documentation supporting the medical necessity of the anesthesia such as:  
- Convulsive disorders;  
- Tremors of the head and body;  
- Cerebral palsy, Parkinson’s Disease;  
- Children too young to cooperate, and/or  
- Uncooperative patient due to brain injury, mental derangement, mental deficiency, diseases of the brains, etc.  
See Medical Policy for other specific conditions. |
| **Standby Anesthesia** | Standby anesthesia is not payable by Blue Cross. |
E. Monitored Anesthesia Care

Adequate sedation and analgesia are important parts of many diagnostic and therapeutic procedures. Various levels of sedation and analgesia (anesthesia) may be used, depending on the patient’s condition and the procedure being performed. The following information addresses the potential role of dedicated anesthesiaproviders during procedures performed in a properly-equipped and staffed outpatient setting.

Overview of Monitored Anesthesia Care

Monitored anesthesia care (MAC) is a spectrum of anesthesia services defined by the type of anesthesia personnel present during a procedure, not specifically by the level of anesthesia needed. Following are statements derived from the American Society of Anesthesiologists’ (ASA) definition of MAC:

- Monitored anesthesia care is a specific anesthesia service for a diagnostic or therapeutic procedure. Indications for MAC include the nature of the procedure, the patient’s clinical condition and/or the potential need to convert to a general or regional anesthetic.

- Monitored anesthesia care includes all aspects of anesthesia care (i.e., pre-procedure visit, intraprocedural care and post procedure anesthesia management). During MAC, the anesthesiologist provides or medically directs a number of specific services, including but not limited to:
  - 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 as necessary for patient safety;
  - Psychological support and physical comfort;
  - Provision of other medical services as needed to complete the procedure safely.

- Monitored anesthesia care may include varying levels of sedation, analgesia and anxiolysis as necessary. The provider of MAC must be prepared and qualified to convert to general anesthesia when necessary. If the patient loses consciousness and the ability to respond purposefully, the anesthesia care is a general anesthetic, irrespective of whether airway instrumentation is required.

Sedation for Diagnostic and Therapeutic Procedures

Multiple diagnostic and therapeutic procedures performed in the outpatient setting, including endoscopy, colonoscopy, bronchoscopy, and interventional pain management procedures, rely on some degree of sedation for anxiolysis and pain control. Regardless of sedation depth, sedation and anesthesia services that are provided in outpatient settings should be administered by qualified and appropriately trained personnel. Moderate sedation is generally sufficient for many diagnostic and uncomplicated therapeutic procedures. Moderate sedation using benzodiazepines, with or without narcotics, is frequently administered under the supervision of the proceduralist.
According to the ASA’s standard for monitoring, MAC should be provided by qualified anesthesia personnel, including physicians and nurse specialists. By this standard, the personnel must be in addition to the proceduralist and present continuously to monitor the patient and provide anesthesia care. For patients at high risk of an unsuccessful procedure under moderate sedation, this allows for the safe continuation of the procedure under deep sedation or general anesthesia by trained personnel.

Propofol is an agent that has been used increasingly to provide sedation for procedures. Propofol is associated with a rapid onset of action and fast recovery from sedation. However, there have been concerns about potential side effects and safety when used by non-anesthesiologists. It has the potential to induce general anesthesia, and there is no pharmacologic antagonist to reverse its action. When used as moderate sedation, propofol may be administered by anesthesia personnel or under the direction of the proceduralist.

Coverage for MAC is provided, but is not limited to, for gastrointestinal endoscopy, bronchoscopy, and interventional pain procedures when there is documentation by the proceduralist and/or anesthesiologist in the patient’s medical record that specific risk factors or significant medical conditions are present. Risk factors or significant medical conditions include any of the following:

- Patients with potential for difficult intubation and/or ventilation with a mask or who are at risk for airway obstruction, including but not limited to:
  - Patients with previous problems with anesthesia or sedation
  - Patients with a history of stridor or tracheal stenosis
  - Patients with a diagnosis of clinically significant sleep apnea
  - Morbidly obese patients
  - Patients with dysmorphic facial features, such as Pierre-Robin syndrome, trisomy 21, or Turner’s syndrome
  - Patients with oral abnormalities, such as a small opening (<3 cm in an adult), macroglossia, tonsillar hypertrophy, or a nonvisible uvula
  - Patients with neck abnormalities, such as limited neck extension, decreased hyoid mental distance (<3 cm in an adult), neck mass, oral or glottic tumors, previous head and neck surgery or radiation, unstable cervical spine, tracheal deviation due to mass or previous surgery, ankylosed cervical spine or advanced rheumatoid arthritis
  - Patients with IX or X cranial nerve impairment
  - Patients with spinal cord instability
  - Patients with jaw abnormalities such as micrognathia, retrognathia, trismus, or significant malocclusion

- Patients with allergies to sedation and analgesia agents
- Alcohol or drug addicted patients or patients with increased tolerance to sedation and analgesic agents such as patients with a chronic pain syndrome
- Patients with increased risk for aspiration (e.g., diabetics with autonomic neuropathy and gastroparesis, achalasia, ascites, swallowing disorders, or bulbar neurologic disorders)
• Patients with chronic degenerative neurologic diseases which may cause difficulty swallowing or pose a risk for muscle weakness and respiratory failure (e.g., multiple sclerosis, myasthenia gravis, Parkinson's disease, amyotrophic lateral sclerosis, etc.)
• Extremes of age (> 70 years of age)
• Patients age 18 and under
• Patients who are pregnant
• Combative or uncooperative patients (e.g., pediatric patients)
• Patients with neurobehavioral delays when rapid onset of sedation is a safety concern
• Patients with a history of severe nausea and/or vomiting after administration of sedation with narcotics and/or benzodiazepines
• Patients undergoing prolonged or complex diagnostic or therapeutic procedures such as endoscopic retrograde cholangiopancreatography (ERCP)
• Class III ASA patients when respiratory and/or cardiac complications are a concern

Class III ASA is defined as severe systemic disease that limits activity, but is not incapacitating [e.g., stable angina, history of myocardial infarction, history of stroke, insulin dependent diabetes and poorly controlled disorders (e.g., hypertension, asthma, psychiatric disorders, dysrhythmias, congestive heart failure, and chronic obstructive pulmonary disease)].

• Class IV ASA patients with a severe systemic disease that limits activity and is a constant threat to life such as:
  – Myocardial infarction within last six months
  – Stroke within last six months
  – Unstable angina
  – Severe congestive heart failure
  – Severe chronic obstructive pulmonary disease
  – Hepatic failure
  – Renal failure
  – Uncontrolled epilepsy

MAC is eligible for coverage when provided for use with interventional pain procedures at the cervical or thoracic level [unless the Physicians' Current Procedural Terminology (CPT) code indicates otherwise] involving the intercostal nerve, sphenopalatine ganglion, stellate ganglion, superior hypogastric plexus, celiac plexus, paravertebral facet (zygapophyseal) joint, and/or injection of a neurolytic agent.

MAC is not eligible for coverage when provided for patients with an average risk related to use of anesthesia and sedation for the following procedures:

• Gastrointestinal endoscopic
• Bronchoscopic
• Interventional pain procedures (including diagnostic, screening or trial blocks)
MAC can be provided by qualified anesthesia personnel with training and experience in:

- Patient assessment
- Continuous evaluation and monitoring of patient physiological functions
- Diagnosis and treatment (both pharmacological and non-pharmacological) of any and all deviations in physiological function

Anesthesia Consultations

Anesthesia consultations are considered part of the global procedure when performed on the day of or days before the procedure unless the anesthesiologist performs the consultation and MAC is not performed. Refer to Consultations vs. Referrals for more details.

Claim Filing Requirements

MAC claims must include one of the physical status modifiers below to indicate assessment of a patient before surgery:

- **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 harvested

Modifier 47 indicates that the procedure did not require an anesthesiologist. Be sure to use this modifier, when appropriate, in order for us to process your claims correctly.

MAC claims for gastrointestinal procedures (CPT codes 00740 and 00810) are considered for coverage with all valid modifiers. CPT codes 00740 and 00810 should not be billed for the same date of service by the same physician.

MAC claims for non-gastric procedures (CPT codes 01991, 01992 and 00520) that do not meet the outlined criteria and are submitted with modifier P1 or P2 will be denied. These claims are subject to medical record review to ensure the criteria is met.

**Exceptions** – The following procedures are considered for coverage when filed with modifier P1 or P2:

43260 43264 43268 43275 62263 64479 64517 64633
43261 43265 43269 43276 62291 64490 64520 64636
43262 43266 43270 43277 62310 64505 64530 64680
43263 43267 43274 43278 64420 64510 64620

Note: Aberrant billing patterns may be subject to review.