HealthLink

Professional Pricing Policy

Subject: **Anesthesia Services**	
Policy Number: HLANP-0001	Policy Section: **Anesthesia**
Last Approval Date: September 1, 2024	Effective Date: December 1, 2024

Disclaimer

These policies serve as a guide to assist you in accurate claims submissions and to outline the basis for allowed amounts for HealthLink members. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or Revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating providers and facilities.

If appropriate coding/billing guidelines are not followed, HealthLink and/or its Payors may:

- *Reject or deny the claim*
- *Recover and/or recoup claim payment*

These policies may be superseded by provider or State contract language, or State, Federal requirements or mandates.

We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or adjust pricing accordingly to the effective date. HealthLink reserves the right to review and revise its policies periodically when necessary. When there is an update, we will publish the most current policy to the website. Note: medical claim pricing and processing services provided by HealthLink are available to a payor; however not all payors purchase such services for the benefit plans they sponsor.

Policy

HealthLink uses a number of factors in determining the allowed amount for a particular anesthesia service. Some of the factors that HealthLink uses, in combination or separately, are:

- Base Units (BU) are assigned to a specific anesthesia CPT code and are derived from the American Society of Anesthesiologists (ASA) Anesthesia Relative Value Guide (RVG)
- Time Units (TU) a time unit is equal to 15 minutes
- Conversion Factors (CF) is a single unit rate used in the calculation for anesthesia to be allowed
- Modifiers are to identify servicing and physical status
- Additional Factors such as qualifying circumstances, field avoidance, and unusual positioning

Anesthesia describes the loss of sensation resulting from the administration of a pharmacologic agent that blocks the passage of pain impulses along nerve pathways to the brain. There are many types of anesthesia, but the three major types are:

- General - anesthesia affecting the entire body and accompanied by a loss of consciousness.
- Regional - loss of all forms of sensation of a particular region of the body.
- Local - loss of sensation in a limited and superficial (i.e. surface) area of the body.

Services involving the administration of anesthesia are reported by using the anesthesia and, if applicable, a physical status modifier and/or a servicing modifier.

I. Time

Anesthesia time begins when the anesthesiologist or qualified healthcare professional begins to prepare

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the patient for anesthesia care in the operating room or in the equivalent area, and ends when the anesthesiologist or qualified healthcare professional is no longer in personal attendance. Anesthesia time can be counted in blocks of time if there is an interruption in anesthesia, as long as the time counted is that in which continuous anesthesia services are provided.

Based on ASA billing guidelines, when anesthesia services are provided for multiple surgical procedures, only the anesthesia procedure code for the most complex service should be reported. Base units are only used for the primary procedure and not for any secondary procedures. If two separate anesthesia codes are reported, the procedure with the lesser charge will be denied. (Exception: Add-on codes 01953, 01968, or 01969, are separately allowed in addition to the code for the primary procedure.)

If HealthLink can determine, based on its review of the anesthesia record, that a separate subsequent operative session took place with more than an hour separation from the initial anesthesia, the second subsequent anesthesia service may be separately allowed.

Time spent performing anesthesia services is reported in one-minute increments and noted in the units field. To calculate the allowed amount for time, the number of minutes reported is divided by 15 (minutes) and rounded up to the next tenth to provide a unit of measure.**

**Example: 61 minutes divided by 15 = 4.0666 units. The allowed amount for time is rounded to 4 . 1 units instead of using a whole 5 unit of measure.

The allowed amount of anesthesia services rendered is calculated by adding the time units to the base units assigned to the anesthesia code reported and multiplying that sum by the contracted conversion factor.**

> **In the example given above, the time units would be 4.1. If the anesthesia code had a base unit of 5, then 4.1 added to 5 would give an allowed amount measure of 9.1. If the anesthesia allowed amount was $50, then 9.1 x $50 =$455

II. Modifiers

a. Servicing Modifiers

- Claims for anesthesia should identify whether a physician/anesthesiologist or non-physician anesthesia provider rendered the anesthesia services. Therefore, HealthLink requires that a servicing modifier (as shown in the table below) must be appended to the reported anesthesia code.
- When a non-physician anesthesia provider bills for anesthesia administration, and a physician/anesthesiologist bills for supervising the non-physician anesthesia provider, services are allowed for both the supervising physician/anesthesiologist and the administering non-physician anesthesia provider according to the appropriate modifier.
- The total allowed amount for anesthesia services provided by a physician/anesthesiologist and a non-physician anesthesia provider (e.g., certified registered nurse anesthetist (CRNA), anesthesia assistant (AA), etc.) will not exceed 100% of the eligible amount that would be allowed had the anesthesia service been provided by only the physician/anesthesiologist.
- The following table identifies servicing modifiers and indicates the applicable percentage of the allowance for such servicing modifier.

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Related

Modifier	Description	Percentage of allowance
AA	Anesthesia services personally performed by anesthesiologist	100%
AD	Medical supervision by a physician: more than 4 concurrent anesthesia procedures	3 base units. This rate is determined by the Conversion Factor x 3 regardless of the base units for the procedure reported. No additional units are allowed such as those for physical status modifiers (P3, P4, and P5), qualifying circumstances, or time.
G8	Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure	When modifier G8 is reported with a general anesthesia service, the general anesthesia service will not be allowed.
G9	Monitored anesthesia care for patient who has history of severe cardiopulmonary condition	When modifier G9 is reported with a general anesthesia service, the general anesthesia service will not be allowed.
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals	50%
QS	Monitored anesthesiology care services (can be billed by a qualified nonphysician anesthetist or a physician)	When modifier QS is reported with a general anesthesia service, the general anesthesia service will not be allowed.
QX	Qualified nonphysician anesthetist with medical direction by a physician	50%
QY	Medical direction of one qualified nonphysician anesthetist by an anesthesiologist	50%
QZ	CRNA without medical direction by physician	85%
SA	Nurse practitioner, physician assistant, clinical nurse specialist, or an advanced practice professional provides services in collaboration with a physician.	85%

- HealthLink requires that servicing modifiers (AA, AD, QK, QX, QY, or QZ) must be reported in the first modifier field of the claim line.
- Please note, when modifier QK, QX, or QY is appended to an applicable spinal/nerve injection code (e.g., 60000 series postoperative pain management/nerve block procedures), the allowed percentage of 50% will apply.
- Informational modifiers G8, G9, or QS may be reported in a subsequent modifier field when the service rendered is monitored anesthesia care (MAC).

b. Physical Status Modifiers

Physical Status Modifiers identify a specific physical condition, which indicates an added level of complexity to the anesthesia service provided. HealthLink follows the ASA recommendation that unit values are assigned to the following physical status modifiers for additional allowance when appended to the base anesthesia code.

- Modifier P3 = *1 unit* (A patient with severe systemic disease)

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- Modifier P4 = *2 units* (A patient with severe systemic disease that is a constant threat to life)
- Modifier P5 = *3 units* (A moribund patient who is not expected to survive without the operation)

HealthLink does not recognize unit values for the following physical status modifiers, and no additional allowed amount will apply.

- Modifier P1 = A normal, healthy patient
- Modifier P2 = A patient with mild systemic disease
- Modifier P6 = A declared brain-dead patient whose organs are being removed for donor purposes

c. Informational Modifiers

- Modifier 47—Anesthesia by Surgeon: Regional or general anesthesia provided by the surgeon may be reported by adding Modifier 47 to the basic service. (Note: This does not include local anesthesia.) Anesthesia services provided by the operating surgeon for a procedure are included in the global rate and are not allowed separately. This modifier is not used as a modifier for anesthesia procedures. (See Anesthesia for Oral Surgery Section V below)
- Modifier 23—Unusual Anesthesia: Occasionally a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. Modifier 23 would be added to the basic procedure code to identify the procedure, due to an unusual circumstance, required general anesthesia. This modifier is informational and does not affect the allowed amount for the reported anesthesia code or the basic procedure.

II. Field Avoidance and Unusual Positioning

HealthLink allows any procedure around the head, neck, or shoulder girdle, requiring field avoidance, or any procedure requiring a position other than supine or lithotomy, has a minimum base value of five regardless of any lesser base value assigned to such procedure. Field avoidance is not eligible for an additional allowed amount, even when reported with modifier 22. Unusual positioning is also note eligible for an additional allowed amount.

III. Qualifying Circumstances for Anesthesia

There may be times when anesthesia services are provided under particularly difficult circumstances depending on factors such as extraordinary condition of patient, notable operative conditions, and unusual risk factors. The following CPT codes are reported in addition to the anesthesia procedure or service provided to identify such qualifying circumstances:

- 99100 Anesthesia for patient of extreme age, younger than 1 year and older than 70

  **See CPT parenthetical statement under anesthesia codes 00326, 00561, 00834, and 00836 for infants younger than 1 year of age

- 99116 Anesthesia complicated by utilization of the total body hypothermia
- 99135 Anesthesia complicated by utilization of controlled hypotension
- 99140 Anesthesia complicated by emergency conditions

Qualifying circumstances codes are allowed separately and are to be reported in addition to the

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anesthesia procedure or service provided. HealthLink will determine when there may be a mutually exclusive relationship with the reported base anesthesia code.

CPT 99140 is separately allowed for emergency services. However, when 99140 is reported for an unscheduled routine obstetric delivery with one of the diagnosis codes listed below, 99140 will **not** be separately allowed.

ICD-10-CM Code	ICD-10-CM Description
O09.511	Supervision of elderly primigravida, first trimester
O09.512	Supervision of elderly primigravida, second trimester
O09.513	Supervision of elderly primigravida, third trimester
O09.519	Supervision of elderly primigravida, unspecified trimester
O09.521	Supervision of elderly multigravida, first trimester
O09.522	Supervision of elderly multigravida, second trimester
O09.523	Supervision of elderly multigravida, third trimester
O09.529	Supervision of elderly multigravida, unspecified trimester
O09.611	Supervision of young primigravida, first trimester
O09.612	Supervision of young primigravida, second trimester
O09.613	Supervision of young primigravida, third trimester
O09.619	Supervision of young primigravida, unspecified trimester
O09.621	Supervision of young multigravida, first trimester
O09.622	Supervision of young multigravida, second trimester
O09.623	Supervision of young multigravida, third trimester
O09.629	Supervision of young multigravida, unspecified trimester
O09.811	Supervision of pregnancy resulting from assisted reproductive technology, first trimester
O09.812	Supervision of pregnancy resulting from assisted reproductive technology, second trimester
O09.813	Supervision of pregnancy resulting from assisted reproductive technology, third trimester
O09.819	Supervision of pregnancy resulting from assisted reproductive technology, unspecified trimester
O09.821	Supervision of pregnancy with history of in utero procedure during previous pregnancy, first trimester
O09.822	Supervision of pregnancy with history of in utero procedure during previous pregnancy, second trimester
O09.823	Supervision of pregnancy with history of in utero procedure during previous pregnancy, third trimester
O09.829	Supervision of pregnancy with history of in utero procedure during previous pregnancy, unspecified trimester
O09.70	Supervision of high risk pregnancy due to social problems, unspecified trimester
O09.71	Supervision of high risk pregnancy due to social problems, first trimester
O09.72	Supervision of high risk pregnancy due to social problems, second trimester
O09.73	Supervision of high risk pregnancy due to social problems, third trimester
O09.891	Supervision of other high risk pregnancies, first trimester
O09.892	Supervision of other high risk pregnancies, second trimester
O09.893	Supervision of other high risk pregnancies, third trimester
O09.899	Supervision of other high risk pregnancies, unspecified trimester
O34.21	Maternal care for scar from previous cesarean delivery
O80	Encounter for full-term uncomplicated delivery

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O82	Encounter for cesarean delivery without indication
Z34.01	Encounter for supervision of normal first pregnancy, first trimester
ICD-10-CM Code	**ICD-10-CM Description**
Z34.02	Encounter for supervision of normal first pregnancy, second trimester
Z34.03	Encounter for supervision of normal first pregnancy, third trimester
Z34.80	Encounter for supervision of other normal pregnancy, unspecified trimester
Z34.81	Encounter for supervision of other normal pregnancy, first trimester
Z34.82	Encounter for supervision of other normal pregnancy, second trimester
Z34.83	Encounter for supervision of other normal pregnancy, third trimester
Z34.90	Encounter for supervision of normal pregnancy, unspecified, unspecified trimester
Z34.91	Encounter for supervision of normal pregnancy, unspecified, first trimester
Z34.92	Encounter for supervision of normal pregnancy, unspecified, second trimester
Z34.93	Encounter for supervision of normal pregnancy, unspecified, third trimester

IV. Anesthesia for Oral Surgery

In order for the related anesthesia of a covered surgical procedure reported with a Current Dental Terminology (CDT) based procedure code (i.e., "D" codes) to be allowed, HealthLink requires the appropriate CDT-based anesthesia code (D9210-D9248) to be reported for the anesthesia service.

** If HealthLink receives a cross-coded claim, (e.g., one containing both CPT and CDT codes), the code reported for the anesthesia service will not be separately allowed until the cross coding is eliminated. For example:

- CPT anesthesia codes 00170-00176, which describe anesthesia for intraoral procedures, will not be allowed when reported with a CDT procedure. The applicable CDT anesthesia code, must be reported for the anesthesia service to be separately allowed.
- CDT anesthesia codes D9210-D9248 will not be separately allowed when reported with a CPT procedure.

When an oral surgeon renders a surgical procedure that is reported with a CPT procedure code, and provides an anesthesia service, HealthLink requires that modifier 47 must be appended to the CPT code. This indicates that the same surgeon performing the procedure also provided the anesthesia. Only the covered oral surgery procedure is allowed. There is no additional allowance for the CPT code appended with modifier 47. (See Informational Modifiers Section 2. c. above.)

V. Services Included/Excluded in the Global Allowance for Anesthesia

Global allowance for the anesthesia service provided includes all procedures integral to the successful administration of anesthesia from the initial pre-anesthesia evaluation through the time when the anesthesiologist or other qualified health care professional in the same anesthesia provider group is no longer in personal attendance.

Below are services that HealthLink considers included or excluded from the global anesthesia allowed amount:

a. Examples of services and corresponding codes that HealthLink considers to be <u>included</u> in the global allowed amount for the anesthesia service and are <u>not</u> separately allowed:

- Daily hospital management of patient controlled analgesia (when a patient controls the amount of analgesia he or she receives)
- Echocardiography (e.g., CPT codes 93303, 93304, 93307, 93308)
- Electroencephalogram (EEG) (e.g., CPT codes 95812, 95813, 95955)
- Inhalation treatments (e.g., CPT code 94640)

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- Laryngoscopy and bronchoscopy procedures (e.g., CPT codes 31505, 31515, 31527, 31622, 31645)
- One-day preoperative evaluation and management (E/M) services and 10-day postoperative E/M services; the 10-day postoperative period includes any E/M services that are a follow-up to the general anesthesia service, as well as any E/M services related to postoperative pain management for the surgical episode. The 10-day postoperative period will apply to the anesthesiologist or other qualified health care professional who performed the general anesthesia, or to other providers in the same anesthesia provider group. Nerve block injections (for pain management) are separately allowed.
- Placement and interpretation of any non-invasive monitoring, which may include ECG testing (e.g., CPT codes 93000-93010, 93040-93042), monitoring of temperature/blood pressure/pulse oximetry (e.g., CPT codes 94760-94761), carbon dioxide, expired gas determination by infrared analyzer/capnography (e.g., CPT code 94770) and mass spectrometry, and vital capacity (e.g., CPT code 94150)
- Placement of endotracheal and naso-gastric tubes (e.g., CPT codes 31500, 43753, 43754)
- Placement of peripheral intravenous lines and administration of fluids, anesthetic or other medications through a needle or tube inserted into a vein (e.g., CPT codes 36000, 96360-96361, 96365-96372)
- Venipuncture and transfusion (e.g., CPT codes 36400-36440)

b. The placement of catheters in arterial, central venous or pulmonary arteries (e.g., CPT codes 36555-36556, 36620, 36625, 93503) are excluded from global allowed amounts and are separately allowed.

c. In accordance with National Correct Coding Initiative (NCCI) coding guidelines, HealthLink requires that if a transesophageal echocardiography (TEE) is performed as a distinct and independent procedure from the anesthesia service provided, then the appropriate modifier must be appended to the TEE code in the code range of 93312-93317 to be allowed separately

d. If TEE services are for monitoring purposes (e.g., CPT code 93318) or guidance of a transcatheter intracardiac or great vessel(s) structural intervention(s) (e.g., CPT code 93355), HealthLink will follow NCCI edit logic and consider the codes incidental and a bypass modifier will not override.

e. When an anesthesiologist, a non-physician anesthesia provider, an anesthesia group, or any other professional provider separately reports a medication in a facility setting, the medication will not be separately allowed even when reported with an unclassified or unspecified drug code. HealthLink considers the provision of any medication, including Propofol, to be included under the facility's charge.

VI. Postoperative Pain Management

a. Postoperative pain management services by an anesthesiologist, such as an injection or catheter insertion into the epidural space or major nerve, are allowed separately. Postoperative pain management services are allowed, and time units are not applicable. This applies to the following codes and ranges: 62320-62327, 64413-64425 and 64445-64450. When postoperative pain management services are performed bilaterally, the unilateral code must be reported once with modifier 50 using the applicable base value for the unilateral code. The pain management code will be considered as one surgical service and is allowed equal to 150% of the allowed amount for the code.

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b. An epidural or major nerve injection or catheter insertion performed by an anesthesiologist for postoperative pain management before, during, and/or following the surgical procedure is separately allowed in addition to the primary anesthesia code. The appropriate modifier must be appended to the appropriate procedure code to indicate a distinct procedural service was performed.

c. The daily hospital management of epidural or subarachnoid continuous drug administration (CPT code 01996) for postoperative pain management performed by the anesthesiologist is allowed once per date of service following the surgery date. However, when the daily management code is reported with an anesthetic injection code such as CPT codes 62320-62327, only the injection code is allowed. Modifiers will not override the edits.

d. HealthLink will deny daily hospital management of epidural or subarachnoid continuous drug administration procedure code when billed with a physical status modifier or qualifying circumstance procedure codes.

Exemptions

Definitions

Anesthesia	Administration of medication to allow medical procedures to be done without pain, and in some cases, without the patient being awake during the procedure.

Related Policies and Materials

Global Surgery

References and Research Materials

This policy has been developed through consideration of the following

- American Medical Association (AMA) Current Procedural Terminology (CPT)
- American Society of Anesthesiologists (ASA) Relative Value Guide
- American Dental Association Current Dental Terminology
- American Association of Professional Coders HCPCS Level II Expert

Use of Pricing Policy

This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member's benefits on the date of service. Pricing Policy is constantly evolving and we reserve the right to review and update these policies periodically.

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