Coding Policy **Policy and Procedure**		
SUBJECT: Coding Policy 09.0 Anesthesia	DEPARTMENT: **Coding Compliance**	
ORIGINAL EFFECTIVE DATE: 03/1991	DATE(S) REVIEWED/REVISED: 1/06 - 01/14, 02/14, 05/14, 09/14, 01/15, 06/15, 01/16, 04/16, 08/16, 01/17, 01/18, 01/19, 04/19, 06/19, 01/20, 2/20, 1/21	
APPROVED BY: Coding Policy Review Committee	NUMBER: **MC 09.0**	PAGE: **1 of 7**

SCOPE:
Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

APPLIES TO:
Health Plan Providers
All Lines of Business

POLICY:
Anesthesia services are allowed when provided by an anesthesiologist and/or anesthetist for an approved, medically necessary procedure that is a covered benefit. Anesthesia services are not paid separately when performed by the same provider who performs the procedure. Anesthesia provided by the surgeon is included in payment for the surgery.

Reimbursement for anesthesia services, as well as injection, drainage, or aspiration, is made in accordance with the current American Society of Anesthesiologist (ASA) guidelines for CPT defined codes 00100 through 01999. CPT codes 62263 through 62319 are paid the same as any other specialty unless specified otherwise in the provider’s contract. Services for CPT codes other than 00100-01999 are reimbursed the same as any other specialty.

Company will determine the fee schedule payment, recognizing the base unit(s) for the anesthesia code and one time unit for each 15 minutes of anesthesia time, if:

- The physician personally performed the entire anesthesia service alone; *or*
- The physician is involved with one anesthesia case with an intern or resident, and the physician is the teaching physician; *or*
- The physician is continuously involved in a single case involving a student nurse anesthetist; *or*
- The physician is continuously involved in one anesthesia case involving a Certified Registered Nurse Anesthetist (CRNA) or Anesthesiology Assistant (AA), and the physician is performing medical direction. The physician will use the modifier “QY” (MEDICAL DIRECTION ONE CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA) BY AN ANESTHESIOLOGIST), and the CRNA or AA will use the modifier “QX.” Each will be paid 50% of the allowance otherwise recognized had the service been furnished by the anesthesiologist alone; *or*
- The physician is involved in the medical direction of 2, 3, or 4 concurrent anesthesia procedures involving CRNA’s. The physician will use the modifier “QK” (MEDICAL DIRECTION OF 2, 3, OR 4 CONCURRENT ANESTHESIA PROCEDURES INVOLVING QUALIFIED INDIVIDUALS) and the CRNA will use the modifier “QX.” Each will be paid 50% of the allowance otherwise recognized had the service been furnished by the anesthesiologist alone; *or*

- The physician and the CRNA or Anesthesiology Assistant (AA) are involved in one anesthesia case and the services of each are found to be medically necessary. Documentation must be submitted by both the CRNA or AA and the physician to support payment of the full fee for each of the two providers. The physician would report using the "AA" modifier and the CRNA or AA (Anesthesia Assistant) would use the "QZ" modifier for a non-medically-directed case.
- The physician is involved in more than 4 concurrent anesthesia procedures. The physician reports using “AD” modifier, and the CRNA reports using the “QX.” The anesthesiologist will be allowed three base units and no time units for procedures billed with modifier AD, with the exception of CPT code 01953. No payment is allowed for code 01953 billed with modifier AD. In addition to three base units, one time unit will also be allowed for codes billed with modifier AD if the anesthesiologist was present at induction and submits documentation showing this.
  - Actual anesthesia time equals 1 unit for each 15 minutes.
  - Monitored anesthesia equals 1 unit for each15 minutes.
  - Continuous obstetrical epidural equals time in attendance with the patient.

When reporting anesthesia services, providers should report the total minutes of anesthesia time provided in the units column on the claim form. Providers may report start and end times; however, this information is not required for claims processing.

Company expects that obstetric anesthesia services will be billed in a fashion that reasonably reflects the costs of providing labor analgesia, as well as the intensity and time involved in performing and monitoring any neuraxial labor analgesic. Obstetric anesthesia is paid using base units plus time units (insertion, management of adverse events, delivery, and removal). Time will be allowed when anesthesiologist is in attendance. Medical records must document time and service. (See also information on Page 5 of this policy.)

PROCEDURE:

Anesthesia services included in the base value and not subject to additional reimbursement are:

1. Usual pre- and postoperative visits
2. The administration of fluids and/or blood products incident to the anesthesia care (including venipuncture and/or introduction of needle or catheter)
3. Laryngoscopy and/or bronchoscopy
4. Nerve blocks (except for postoperative pain management requested by the surgeon, see Page 3)
5. Retrobulbur injection
6. Cardiopulmonary resuscitation, cardioversion, temporary pacemaker, or inhalation treatments

7. Anesthesia care during the procedure
8. Monitored functions such as:
   - Oximetry
   - EKG Monitoring
   - Equipment
   - Intubation (at time of procedure)
   - Ventilation management *
   - Extremity arterial venous studies
   - Blood gases
   - Blood pressure monitoring
   - Capnography
   - Carbon Dioxide monitoring (CO2)
   - Urinalysis
   - Cardiovascular stress tests
   - Nasal, Laryngeal or swallowing function studies
   - Transthoracic and/or Transesophageal Echocardiography

* If performed during surgical procedure

Anesthesia services begin when the physician or anesthetist begins to prepare the patient for anesthesia care in the operating room or equivalent area and ends when the anesthesiologist is no longer in personal attendance, i.e., when the patient may be safely placed under postoperative supervision.

Anesthesia services not included in the base value and may be billed separately are:

1. Placement of arterial, central venous, and pulmonary artery catheters.
2. Injections for Postoperative Pain Control Billed by Anesthesiologist:
   a. An epidural injection (CPT codes 623XX) for postoperative pain management requested by the surgeon may be reported separately with an anesthesia (0XXXX) code only if the mode of intraoperative anesthesia is general anesthesia and the adequacy of the intraoperative anesthesia is not dependent on the epidural or peripheral block injection.
   b. A peripheral nerve block injection (CPT codes 64XXX) for postoperative pain management requested by the surgeon may be reported separately with an anesthesia (0XXXX) code only if the mode of intraoperative anesthesia is general anesthesia, subarachnoid injection, or epidural injection, and the adequacy of the intraoperative anesthesia is not dependent on the peripheral nerve block injection.
   c. An epidural or peripheral nerve block injection administered preoperatively or intraoperatively is not separately reportable for postoperative pain management if the mode of anesthesia for the procedure is MAC, moderate conscious sedation, regional anesthesia by peripheral nerve block, or other type of anesthesia not identified above.

Postoperative Pain Control Billed by Facilities

Reimbursement to facilities for the control or management of pain in the immediate postoperative period is packaged into payment for the surgical or anesthetic procedure, regardless of the method

by which the care provider, including the anesthesiologist, decides to manage pain. Following discharge from the post-anesthesia care unit (PACU), medically necessary and reasonable placement of regional or peripheral pain blocks or initiation of other new pain interventions or "top-up" dosing may be separately reimbursable in the outpatient setting. Facilities should not expect separate payment for the establishment of epidural or other pain blocks unless the block is placed following discharge from PACU when documentation supports the intervention.

Physical Status Modifiers

Physical status modifiers are not recognized for Medicare or OHP members.

Physical status modifiers are allowed for lines of business other than Medicare and OHP subject to ASA Guidelines. **Documentation to support the charge must be included in the medical record.**

- Physical Status Modifier 1:
  - A normal healthy patient. (No additional time units paid.)
- Physical Status Modifier 2:
  - A patient with mild systemic disease. (No additional time units paid.)
- Physical Status Modifier 3:
  - A patient with severe systemic disease. (One additional time unit paid.
- Physical Status Modifier 4:
  - A patient with severe systemic disease that is a constant threat to life. (Two additional time units paid.)
- Physical Status Modifier 5:
  - A moribund patient who is not expected to survive without the operation. (Three additional time units paid.)
- Physical Status Modifier 6:
  - A declared brain-dead patient whose organs are being removed for donor purposes. (No additional time units paid.)

ASA PS Category	Preoperative Health Status	Comments, Examples
*ASA PS classifications from the American Society of Anesthesiologists		
ASA PS 1	Normal healthy patient	No organic, physiologic, or psychiatric disturbance; excludes the very young and very old; healthy with good exercise tolerance
ASA PS 2	Patients with mild systemic disease	No functional limitations; has a well-controlled disease of one body system; controlled hypertension or diabetes without

ASA PS Category	Preoperative Health Status	Comments, Examples
		systemic effects, cigarette smoking without chronic obstructive pulmonary disease (COPD); mild obesity, pregnancy
ASA PS 3	Patients with severe systemic disease	Some functional limitation; has a controlled disease of more than one body system or one major system; no immediate danger of death; controlled congestive heart failure (CHF), stable angina, old heart attack, poorly controlled hypertension, morbid obesity, chronic renal failure; bronchospastic disease with intermittent symptoms
ASA PS 4	Patients with severe systemic disease that is a constant threat to life	Has at least one severe disease that is poorly controlled or at end stage; possible risk of death from anesthesia; unstable angina, symptomatic COPD, symptomatic CHF, hepatorenal failure
ASA PS 5	Moribund patients who are not expected to survive without the operation	Not expected to survive > 24 hours without surgery; imminent risk of death; multiorgan failure, sepsis syndrome with hemodynamic instability, hypothermia, poorly controlled coagulopathy
ASA PS 6	A declared brain-dead patient whose organs are being removed for donor purposes	

Patients with multiple PS 3 conditions may qualify as PS 4.
PS modifier 5 may be subject to medical review.

Obstetrical Anesthesia
Continuous epidural analgesia for labor and delivery will be allowed at base units plus patient contact time. Time will be allowed when anesthesiologist is in attendance. Medical records must document time and service.

Qualifying Circumstances
Qualifying circumstances (CPT codes 99100, 99116, 99135, and 99140) are not recognized for Medicare or Medicaid members.

Qualifying circumstances are allowed for other lines of business subject to the ASA Guidelines.

Emergency qualifying circumstances (CPT code 99140) are not allowed for planned cesarean sections or for normal vaginal labor and delivery. If a general anesthetic is administered for a vaginal delivery, an emergency modifier may apply. **Emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part.**

Monitored Anesthesia
Monitored anesthesia is reimbursed the same as general or regional anesthetic. Risk factors are allowed. **CPT codes 00731 (*Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; not otherwise specified*) and 00811 (*description below*) are not paid in an ambulatory surgery setting or non-hospital based outpatient setting without prior authorization. Charges will be denied as provider responsibility. For additional information, refer to PHP Medical Policy "Anesthesia with Endoscopy," which is available on ProvLink.**

Monitored Anesthesia for Screening Colonoscopy
Company requires prior authorization (PA) for monitored anesthesia care (MAC) performed for diagnostic endoscopy (CPT code 00811). A PA is not required for MAC performed for screening colonoscopy (CPT code 00812).

- 00811: Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified
- 00812: Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy

For Medicare members only: When screening colonoscopy is converted to diagnostic colonoscopy, the Centers for Medicare and Medicaid Services (CMS) advises anesthesia providers to add modifier PT to the anesthesia code for diagnostic colonoscopy, CPT code 00811. Company allows CPT code 00811-PT for MAC only for Medicare members.

For Commercial and OHP members: Company follows CPT guidelines, which state CPT code 00812 is used for screening colonoscopy, regardless of findings. This option may also be used for Medicare members at the provider's discretion.

Anesthesia Consultations
Anesthesia consultations are allowed if care is initiated and/or recommended as a result of the consult.

Consultations are not allowed if performed as a pre-anesthesia evaluation in preparation for a surgical procedure. This service is included in the base rate. Covering anesthesiologists may not bill additional fees for this service.

Field Avoidance

Additional payment for field avoidance is allowed subject to the following:

- The base value is less than 5 units, *and*
- The procedure is performed around the head, neck, or shoulder girdle, *and/or*
- The procedure requires a position other than supine.

Additional units up to the base value of 5 are allowed. Additional payment for field avoidance is not allowed for procedures with a base value of 5 or more units.

There is no modifier that identifies field avoidance; it is only paid by review. Provider will need to request a review with documentation.

Ventilation Set Up and Assessment

These services are separately reimbursable if performed after transfer out of post-anesthesia recovery to a hospital unit/ICU.

Daily Management of Epidural or Subarachnoid Drug Administration

The Plan does not expect to see more than two visits per day and service should not exceed eight service days. Documentation may be requested to support these charges.

Medical or Surgical Services

Services listed in CPT as medical or surgical are reimbursed based on CMS/Medicare Rules (RBRVS).

Company reserves the right to review the medical records related to the services provided.

REFERENCE:

- Current Procedural Terminology (CPT)
- CMS/Medicare Administrative Rules and Regulations
- Providence Health Plan Coding Edits
- National Correct Coding Initiative Guidelines