MEDICAL COVERAGE POLICY	
SERVICE:	**Anesthesia Professional Reimbursement**
Policy Number:	**289**
Effective Date:	**05/01/2021**
Last Review:	**03/25/2021**
Next Review Date:	**03/25/2022**

Important note:
Unless otherwise indicated, this policy will apply to all lines of business.
Even though this policy may indicate that a particular service or supply may be considered medically necessary and thus covered, this conclusion is not based upon the terms of your particular benefit plan. Each benefit plan contains its own specific provisions for coverage and exclusions. Not all benefits that are determined to be medically necessary will be covered benefits under the terms of your benefit plan. You need to consult the Evidence of Coverage (EOC) or Summary Plan Description (SPD) to determine if there are any exclusions or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and your plan of benefits, the provisions of your benefits plan will govern. However, applicable state mandates will take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, Federal mandates will apply to all plans. With respect to Medicare-linked plan members, this policy will apply unless there are Medicare policies that provide differing coverage rules, in which case Medicare coverage rules supersede guidelines in this policy. Medicare-linked plan policies will only apply to benefits paid for under Medicare rules, and not to any other health benefit plan benefits. CMS's Coverage Issues Manual can be found on the CMS website. Similarly, for Medicaid-linked plans, the Texas Medicaid Provider Procedures Manual (TMPPM) supersedes coverage guidelines in this policy where applicable.

SERVICE: Anesthesia Professional Reimbursement

PRIOR AUTHORIZATION: Not applicable.

POLICY: Please review the plan's EOC (Evidence of Coverage) or Summary Plan Description (SPD) for coverage details.

For Medicare plans, please refer to appropriate Medicare NCD (National Coverage Determination) or LCD (Local Coverage Determination). If there is no applicable NCD or LCD, use the criteria set forth below.

For Medicaid plans, please confirm coverage as outlined in the Texas Medicaid TMPPM.

Anesthesia Base Units and Time Factors. Each CPT anesthesia code is assigned a Base Unit by the Centers for Medicare Services (CMS). SWHP/FirstCare uses these values for determining reimbursement.

Compensation for anesthesia services is based on standard CMS and American Society of Anesthesiologists (ASA) method pricing: (Time Units + Base Units) x Anesthesia Conversion Factor. SWHP/FirstCare requires that the appropriate anesthesia modifier be filed on anesthesia services as well as the duration of the procedure in minutes.

The time units and modifying units vary with each case, but the base units are constant for a given procedure. Anesthesia time is defined as the continuous presence of the anesthesiologist or anesthetist. It starts when the patient is first prepared for anesthesia care and ends when the patient is placed under postoperative supervision. Time units are determined based on one (1) time unit for each 15 minutes of anesthesia. Report the actual anesthesia time in minutes. When actual anesthesia time is not in equal increments of 15 minutes, time units are computed by dividing the reported anesthesia time by 15 minutes, and rounding to one decimal place (nearest 10th). If system constraints prohibit rounding using decimal, SWHP/FirstCare rounds up to allow a full-time unit when the actual anesthesia time is or exceeds eight (8) minutes of a single 15-minute time unit.

The following table identifies the source of each component that is utilized in anesthesia method pricing:

Component	Source of Information
Total number of minutes	Submitted on the claim by the Provider
Time Units	Submitted on the claim by the Provider
Base Units	Obtained from CMS
Conversion Factor	SWHP/FirstCare contracted rate

Physical Status and Qualifying Circumstances. Many anesthesia services are provided under different circumstances and/or when the patient's physical status is impaired. This adds to the complexity of the anesthesia service and may be reported by utilizing physical status modifiers and/or qualifying circumstance codes. When reporting these modifiers/codes, additional units may be allowed and combined with the base unit value for the anesthesia service performed.

Physical Status Modifiers – to be billed by Anesthesiologists and/or CRNAs

Physical Status Modifier	Value(s)
P1 - A normal healthy person:	0 units
P2 - A patient with mild systemic disease:	0 units
P3 - A patient with severe systemic disease:	1 unit
P4 - A patient with severe systemic disease that is a constant threat to life:	2 units
P5 - A moribund patient who is not expected to survive without the operation:	3 units
P6 - A declared brain dead patient whose organs are being removed for donor purposes:	0 units

Qualifying Circumstances – to be billed by Anesthesiologists and/or CRNAs

Codes to be listed separately in addition to code for primary procedure.

Codes	Value(s)
99100 - Anesthesia for patients 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 by emergency conditions (specify):	2 units

Medical and Surgical Services Provided by Anesthesiologists. In addition to providing anesthesia care, anesthesiologists may perform the following medically necessary surgical and medical services, which are subject to all current claims processing guidelines:

- Swan-Ganz catheter insertion
- Central Venous Pressure (CVP) line insertion
- Intra-arterial lines insertion
- Transesophageal echocardiography

An anesthesiologist may provide emergency intubation (CPT 31500) services. However, these services are considered to be an integral part of the anesthesia care, whether provided in an emergency or not, and are included in the base anesthesia services. Emergency intubation not rendered in conjunction with anesthesia services is reimbursable.

Administering Nerve Blocks: CPT 64400 - 64530. Time spent by an anesthesiologist administering a nerve block (i.e.; injecting an anesthetic agent into or around a given nerve) is included in the total anesthesia time. Therefore, it is not eligible for separate reimbursement.

- 64400 - Injection, anesthetic agent; trigeminal nerve, any division or branch
- 64402 - Injection, anesthetic agent; facial nerve
- 64405 - Injection, anesthetic agent; greater occipital nerve
- 64408 - Injection, anesthetic agent; vagus nerve
- 64410 - Injection, anesthetic agent; phrenic nerve
- 64413 - Injection, anesthetic agent; cervical plexus
- 64415 - Injection, anesthetic agent; brachial plexus, single
- 64416 - Injection, anesthetic agent; brachial plexus, continuous infusion by catheter (including catheter placement)
- 64417 - Injection, anesthetic agent; axillary nerve
- 64418 - Injection, anesthetic agent; suprascapular nerve
- 64420 - Injection, anesthetic agent; intercostal nerve, single
- 64421 - Injection, anesthetic agent; intercostal nerves, multiple, regional block
- 64425 - Injection, anesthetic agent; ilioinguinal, iliohypogastric nerves
- 64430 - Injection, anesthetic agent; pudendal nerve

Additional reimbursement is warranted when identified as a distinct procedure by use of modifier 59, for example, if a nerve block is performed primarily for postoperative pain management. Please note that appropriate use of this modifier may be subject to review and all current claim-processing guidelines. When the nerve block is billed alone and is for the treatment of a non-surgical condition, it should be billed under the appropriate injection/block code. SWHP/FirstCare allows separate reimbursement for covered non-surgical nerve block procedures subject to all current claims processing guidelines.

Administering Conscious Sedation: CPT 99151-99152. SWHP/FirstCare does not provide separate reimbursement for conscious sedation. These codes are not billable by anesthesiologists. Further, conscious sedation administered in conjunction with diagnostic, therapeutic, or minor procedures are considered integral to the provision of the primary service.

Patient Controlled Analgesia. Patient controlled analgesia (PCA) pain management involves the self-administration of intravenous drugs through an infusion device. When PCA is initiated, SWHP/FirstCare reimburses the initial catheter insertion, if not part of a surgical anesthesia. Time units and anesthesia base units are not applicable in this instance. SWHP/FirstCare provides reimbursement for postoperative PCA evaluation and management services when billed with an appropriate evaluation and management code, with appropriate supporting documentation.

Epidural Anesthesia. Epidural anesthesia involves the administration of a narcotic drug either through an epidural catheter or by single dose injection. When eligible, SWHP/FirstCare reimburses for the insertion of the epidural catheter and injection when reported with CPT codes 62320, 62321, 62322, 62323 62324, 62325, 62326 62327.

- 62320 Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance
- 62321 Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (i.e., fluoroscopy or CT)
- 62322 Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances,

including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance

- 62323 Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (i.e., fluoroscopy or CT)
- 62324 Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance
- 62325 Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (i.e., fluoroscopy or CT)
- 62326 Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance
- 62327 Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (i.e., fluoroscopy or CT)

With the exception of obstetrical care (see below), if an epidural is the mode of anesthesia for a surgical procedure, reimbursement is based on the surgical procedures base and time units. Separate reimbursement is not provided for the epidural insertion. When providing epidural-related services for obstetrical care, the actual anesthesia time should be reported.

When eligible, SWHP/FirstCare reimburses:

- One (1) time unit per hour of labor for obstetrical patients receiving a continuous infusion epidural.
- One (1) time unit for each 15 minutes of actual delivery time. In the absence of a definitive time, SWHP/FirstCare uses a delivery time of one (1) hour.
- Continuous epidural anesthesia on labor and delivery services should be reported using either ASA code 01967 (vaginal delivery) or codes 01967 and 01968 (cesarean delivery).

If the mode of anesthesia during labor is converted to general anesthesia for the delivery, report ASA code 01960 (vaginal delivery) or code 01961 (cesarean delivery) plus the labor and delivery time. SWHP/FirstCare reimburses for these base/time units in addition to units relating to anesthesia service (labor epidural).

Postoperative and Therapeutic Pain Management. Various methods of postoperative and therapeutic pain management exist, including the use of epidural analgesia. Epidural analgesia involves the administration of a narcotic drug or local anesthetic either through an epidural catheter or by a single dose injection. SWHP/FirstCare reimburses the eligible insertion of the epidural when performed for therapeutic, non-surgical, pain management.

- Epidural and nerve blocks performed for postoperative pain management, if they are not the mode of anesthesia, are eligible for reimbursement when identified by modifier-59 as a distinct procedure.
- Daily management of the therapeutic epidural administration (ASA code 01996) are considered eligible and a separately reimbursable service once per date of service excluding the day of insertion.
- Reimbursement will not be allowed for both the catheter insertion and the daily management of the drug when done on the same day.
- Daily management services beyond three (3) days are subject to clinical review to determine if the service(s) meet Coverage Policy Bulletin guidelines.

Mobile Anesthesia Charges. SWHP/FirstCare does not provide separate reimbursement for the use of office equipment needed for administration of anesthesia regardless of whether it is onsite or must be transported to the physician's office. For office-based surgical procedures, charges for the transportation and set up of equipment for the administration of anesthesia are not eligible for reimbursement. Transportation and setup of equipment is considered incidental to and included in the global surgical package for the procedure performed and is not separately payable.

Certified Registered Nurse Anesthetist (CRNA). A Certified Registered Nurse Anesthetist (CRNA) is a registered nurse who is licensed by the state in which they practice. SWHP/FirstCare recognizes a CRNA as an eligible practitioner under a signed provider contract or state mandate.

Reimbursement for the administration of anesthesia under these circumstances is based on the base unit value assigned to the surgical procedure plus time units and eligible modifying units (if any). Medically directed CRNA services will be paid at 50% of the calculated reimbursement. A separate charge for the medical direction by a physician will be considered, up to the remaining 50%, when billed by the physician. When a CRNA is not medically directed, the fill allowed rate is considered payable to the CRNA. SWHP/FirstCare will not pay more than 100% of the total eligible calculated reimbursement for the combined medical direction and CRNA services.

Medical Direction and Supervision of Anesthesia Administration. SWHP/FirstCare considers the personal medical direction by a physician or anesthesiologist of a qualified CRNA as eligible reimbursement.

When billing for the medical direction of anesthesia procedures, use the following HCPCS modifiers:	
Modifier	**Description**
AD	Medical supervision by a physician; more than four (4) concurrent anesthesia procedures.
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals.
QY	Medical direction of one (1) CRNA by an anesthesiologist.
QX	CRNA service with medical direction by a physician

Reimbursement for the administration of anesthesia under these circumstances is based on the base unit value assigned to the surgical procedure plus time units and eligible modifying units (if any). Reimbursement for the physician or anesthesiologist's medical direction service is determined based on up to 50% of the allowance of the procedure performed. A charge for the medically directed or supervised CRNA service will be considered, up to the remaining 50%, when billed separately. SWHP/FirstCare does not reimburse more than 100% of the total eligible calculated reimbursement for the combined medical direction/supervision and CRNA services.

Unusual Anesthesia (CPT Modifier-23). Under unusual circumstances, general anesthesia may be performed for procedures that typically require local or regional anesthesia or no anesthesia at all. The modifier, “23” should be submitted with the appropriate procedure code to report unusual anesthesia. This modifier should not be reported with procedure codes that include the term, “without anesthesia” in the description or for procedures that are normally performed under general anesthesia.

SWHP/FirstCare will review unusual anesthesia claim submissions on an individual consideration basis and will provide reimbursement for medically necessary services at the allowance rate of three base units per procedure plus time units and eligible modifying units (if any). Documentation to support the reported service must be provided with the claim.

Definitions

Word/Term/Abbreviation	Definition
Deep Sedation	A drug-induced depressed level of consciousness that patients cannot be easily aroused but respond purposefully after repeated or painful stimuli. Airway intervention may be required. Patients may require assistance to maintain a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.
Epidural Anesthesia	The administration of a narcotic drug either through an epidural catheter or by a single dose injection.
General anesthesia	A drug induced loss of consciousness in which patients are not arousable even by painful stimuli. Patients require assistance in maintaining a patent airway; positive pressure ventilation may be required due to depressed spontaneous ventilation or drug induced depression or neuromuscular function. Cardiovascular function may be impaired.
MAC	Monitored Anesthesia Care
Micrognathia	A lower jaw that is smaller than normal.
Minimal Sedation	A drug induced state that patients respond normally to verbal commands and airway, ventilation, and cardiovascular function remain unaffected.
Moderate Sedation (conscious sedation)	A drug-induced depressed level of consciousness that patients can purposefully respond to verbal command or tactile stimulation. No airway intervention is required. Ventilation is adequate and cardiovascular function is usually maintained.
ntrolled Analgesia (PCA)	Pain management that involves the self-administration of intravenous drugs through an infusion device.
Pierre Robin syndrome	A condition present at birth, in which the infant has a smaller-than-normal lower jaw, a tongue that falls back in the throat, and difficulty breathing.
Retrognathia	A condition in which either or both jaws recede with respect to the frontal plane of the forehead.
Trismus	Inability to open the mouth fully.
Trisomy 21	“Down syndrome” Trisomy 21 is caused by an extra chromosome (chromosome 21) originates in the development of either the sperm or the egg.

Applicable Billing Codes

Reimburse additional anesthesia units for the following physical status modifiers:	
Physical Status Modifiers	**Description**
23	Unusual Anesthesia
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

Reimburse additional anesthesia units for the following qualifying circumstances:	
CPT Code	**Description**
99116	Anesthesia complicated by utilization of total body hypothermia (List separately in addition to code for primary anesthesia procedure)
99135	Anesthesia complicated by utilization of controlled hypotension (List separately in addition to code for primary anesthesia procedure)

Do not reimburse separately and the following are not reimbursable by an anesthesiologists:	
CPT Code	**Description**
99151	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient younger than 5 years of age
99152	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes intraservice time (List separately in addition to code for primary service)

Reimburse under the physician fee schedule the following services when furnished by the anesthesiologist:	
CPT Code	**Description**
93503	Swan-Ganz catheter insertion
36555	Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age
36556	Insertion of non-tunneled centrally inserted central venous catheter; age 5 years or older
36568	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; younger than 5 years of age
36569	Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; age 5 years or older
36580	Replacement, complete, of a non-tunneled centrally inserted central venous catheter, without subcutaneous port or pump, through same venous access
36584	Replacement, complete, of a peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, through same venous access
36620	Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous

36625	Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); cutdown
93312	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); including probe placement, image acquisition, interpretation and report
93313	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); placement of transesophageal probe only
93314	Echocardiography, transesophageal, real-time with image documentation (2D) (with or without M-mode recording); image acquisition, interpretation and report only
93315	Transesophageal echocardiography for congenital cardiac anomalies; including probe placement, image acquisition, interpretation and report
93316	Transesophageal echocardiography for congenital cardiac anomalies; placement of transesophageal probe only
93317	Transesophageal echocardiography for congenital cardiac anomalies; image acquisition, interpretation and report only
93318	Echocardiography, transesophageal (TEE) for monitoring purposes, including probe placement, real time 2-dimensional image acquisition and interpretation leading to ongoing (continuous) assessment of (dynamically changing) cardiac pumping function and to therapeutic measures on an immediate time basis

Reimburse CRNAs for covered CRNA services when reported with one of the following HCPCS modifiers:	
Modifier	**Description**
QX	CRNA service with medical direction by a physician.
QZ	CRNA service without medical direction by a physician.

POLICY HISTORY:

Status	Date	Action
New	03/25/2021	Transitioned from FirstCare policy. Removed MAC restrictions

REFERENCES:

The following scientific references were utilized in the formulation of this medical policy. The health plan will continue to review clinical evidence related to this policy and may modify it at a later date based upon the evolution of the published clinical evidence. Should additional scientific studies become available and they are not included in the list, please forward the reference(s) to the health plan so the information can be reviewed by the Medical Coverage Policy Committee (MCPC) and the Quality Improvement Committee (QIC) to determine if a modification of the policy is in order.

1. American Society of Anesthesiologists (ASA). Retrieved from https://www.asahq.org/quality-and-practice-management/standards-guidelines-and-related-resources-search
2. American Society of Anesthesiologists (ASA) Distinguishing monitored anesthesia care ("MAC") from moderate sedation/analgesia. Amended October 21, 2009. Last accessed August 2012.
3. American Society of Anesthesiologists (ASA). Position on monitored anesthesia care (Amended October 16, 2013). 2013
4. American Society of Anesthesiologists Task Force on Sedation and Analgesia by NonAnesthesiologists. Practice guidelines for sedation and analgesia by non-anesthesiologists. Anesthesiology 2002; 96: 1004-17
5. Sedation and anesthesia in GI endoscopy. Accessed on November 14, 2013. Retrieved from https://www.guideline.gov/