blue of california

Payment Policy

Anesthesia Services	
Original effect date:	Revision date:
10/01/2010	01/01/2022

IMPORTANT INFORMATION

Blue Shield of California payment policy may follow industry standard recommendations from various sources such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), Current Procedural Terminology (CPT) and/or other professional organizations and societies for individual provider scope or other coding guidelines. The above referenced payment policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms or their electronic equivalent. This payment policy is intended to serve as a general overview and does not address every aspect of the claims reimbursement methodology. This information is intended to serve only as a general reference regarding Blue Shield's payment policy and is not intended to address every facet of a reimbursement situation. Blue Shield of California may use sound discretion in interpreting and applying this policy to health care services provided in a particular case. Furthermore, the policy does not address all payment attributes related to reimbursement for health care services provided to a member. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy such as coding methodology, industry-standard reimbursement logic, regulatory/legislative requirements, benefit design, medical and drug policies. Coverage is subject to the terms, conditions and limitation of an individual member's programs benefits.

Application

Anesthesia services consist of the administration of a drug or anesthetic agent in one of the following types of anesthesia:

- **General anesthesia:** Loss of ability to perceive pain associated with loss of consciousness produced by intravenous infusion of drugs or inhalation of anesthetic agents.
- **Regional anesthesia:** Use of local anesthetic solution(s) to produce circumscribed areas of loss of sensation. This includes nerve blocks, spinal, epidural, and field blocks. Local infiltration or topical application of an anesthetic into or onto the operative site is local, rather than regional anesthesia.
- **Monitored Anesthesia Care (MAC):** MAC is called monitored anesthesia care because a patient's vitals are constantly monitored to assess pain control and vital functions. The level of sedation administered depends on the health of the patient and the type of surgical or diagnostic procedure being done. This type of anesthesia is typically used for outpatient procedures where the patient will be

going home once the anesthesia wears off. Surgical procedures that use MAC include:
    - endoscopy
    - dental procedures
    - bronchoscopy
    - eye surgery
    - otolaryngologic surgery
    - cardiovascular surgery
    - neurosurgery
    - pain management procedures
- **Moderate (conscious) sedation:** A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.
- **Epidural and Spinal anesthesia:** Epidural and spinal blocks are types of anesthesia in which a local anesthetic is injected near the spinal cord and nerve roots. It blocks pain from an entire region of the body, such as the belly, the hips, the legs, or the pelvis. Epidural and spinal anesthesia are used mainly for surgery of the lower belly and the legs.
    - ***Spinal anesthesia*** (or spinal anesthesia), also called spinal block, subarachnoid block, intradural block and intrathecal block, is a form of neuraxial regional anesthesia involving the injection of a local anesthetic or opioid into the subarachnoid space, generally through a fine needle, usually 9 cm (3.5 in) long.
    - ***Epidural anesthesia*** is a technique whereby a local anesthetic drug is injected through a catheter placed into the epidural space. Epidural anesthesia is often used in childbirth.

Policy

The American Society of Anesthesiology (ASA) guidelines and the Centers for Medicare and Medicaid Services (CMS) payment rules are used as a foundation for developing Blue Shield of California's payment policy for anesthesia services. Anesthesia values are generally determined by a Base unit, plus Modifying units (if any) plus Time units multiplied by the regional conversion factor (CF).

Time units are calculated at one unit per 15 minutes*. Actual anesthesia time should be reported in minutes.

*epidural anesthesia time in labor / delivery may have different consideration – see Obstetrics Anesthesia section below.

{Base unit(s) + Modifying unit(s) (if any)} + Time units} x Conversion Factor = Anesthesia Reimbursement

Anesthesia time begins when the anesthesiologist is first in attendance with the patient for induction of anesthesia and ends when the anesthesiologist is no longer in personal

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

Blue Shield also recognizes that CRNA's may now operate independently, without supervision.

Anesthesia services may include, but are not limited to, the following:

- **General anesthesia**
- **Regional anesthesia**
- **Monitored Anesthesia Care (MAC)**
- **Moderate sedation**
- **Epidural or subarachnoid anesthesia**
- **Other miscellaneous services**
  - Other supportive services in order to afford the patient the anesthesia care deemed optimal by the anesthesiologist during any procedure
  - Usual preoperative and postoperative visits
  - Anesthesia care during the procedure
  - Administration of fluids and/or blood
  - Usual monitoring services (such as electrocardiogram, echocardiogram, temperature, transesophageal echocardiography, blood pressure, oximetry, capnography and mass spectrometry)

Physical Status Modifiers:
Physical status modifiers indicate various levels of complexity of the anesthesia service provided. When these modifiers/codes are reported, additional ASA units may be allowed and combined with the base unit value for the anesthesia service performed.

Blue Shield will reimburse additional anesthesia units for the following physical status modifiers as noted in the table below.

Modifier	Description	Unit
P1	A normal healthy patient	0
P2	A patient with mild systemic disease	0
P3	A patient with severe systemic disease	1
P4	A patient with severe systemic disease that is a constant threat to life	2
P5	A moribund patient who is not expected to survive without the operation	3
P6	A declared brain-dead patient whose organs are being removed for donor purposes	0

Medical Direction & Supervision of Anesthesia Administration
Blue Shield of California requires Physicians to use the applicable modifiers when they are providing Medical Supervision (Modifier AD) or Medical Direction (Modifier QY or QK), of CRNA's, interns or residents. There following modifiers will have the following payment methodology applied to the anesthesia services:

- **Modifier AD:** Medical Supervision – Allowance is reduced by 50% when the physician (anesthesiologist) provides supervision but is not the primary anesthetist/ anesthesiologist.

- **Modifier QY:** Medical Direction of one CRNA – Allowance is reduced by 50% when the physician (anesthesiologist) provides medical direction but is not the primary anesthetist/ anesthesiologist.
- **Modifier QK:** Medical Direction of two, three and four CRNA's – Allowance is reduced by 50% when the physician (anesthesiologist) provides medical direction but is not the primary anesthetist/ anesthesiologist.

Certified Registered Nurse Anesthetists
Blue Shield of California requires CRNA's to use the applicable modifiers when they are providing Anesthesia services. The Payment for certified registered nurse anesthetists (CRNA) services, when allowable are as follows:

- **Monitored Anesthesia Care–CRNA:** Modifier QS when used by a CRNA would be paid at 100% of the Blue Shield Provider Allowance.
- **Medical Direction–CRNA:** Modifier QX when used by a CRNA would be paid at 50% of the Blue Shield Provider Allowance.
- **Anesthesia Services without Medical Direction–CRNA:** Modifier QZ when used by a CRNA would be paid at 100% of the Blue Shield Provider Allowance.

All CRNA claims must be billed with one of the modifiers (QS, QX, or QZ) noted in this payment policy or the claim will be denied.

Unusual Anesthesia (Modifier – 23)
Under unusual circumstances, general anesthesia may be performed for procedures that typically require local or regional anesthesia or no anesthesia at all. Blue Shield considers modifier 23 informational, and therefore there is no additional reimbursement is allowed for the use of Modifier 23 (Unusual Services).

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

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

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

- **01996:** Daily hospital management of epidural or subarachnoid continuous drug administration

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

Moderate Sedation Services:
Consistent with CMS and CPT guidelines and national standards:

- Moderate sedation will be reimbursed when the physician who performs, supervises, or monitors the moderate sedation (CPT 99151-99153, G0500) is the same physician who performs the procedure that requires the moderate sedation.
- Moderate sedation will not be reimbursed, even when a second physician other than the physician performing the diagnostic or therapeutic service, provides moderate sedation (CPT 99155-99157) in the non-facility setting (e.g., physician office, free- standing imaging center).

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

- The time spent on pre- or postoperative placement of the block is separate and clearly not included in the reported/billed general anesthesia time when the nerve block is being performed on the same day of service as general anesthesia services. *National Correct Coding Edits (NCCI) and Mutually Exclusive Edits will be applied as applicable.
- The nerve block is billed with modifier -59 to verify that it is a distinct procedural service as indicated above, when general anesthesia services are also provided on the same day of service.
- Anesthesia base and time units are not applicable for nerve blocks. Nerve blocks are reimbursable in accordance with Blue Shield of California's established professional fee schedule amounts. This is applicable for nerve blocks administered alone or in conjunction with (on the same day) general anesthesia services.
- When the nerve block is billed alone, it should be billed under the appropriate injection/block code.
- For most nerve blocks, image guidance is not usually required and if used would be considered to be included as part of the procedure. Separate imaging charges are subject to medical necessity review. Facet joint injections or medial branch nerve blocks should be performed using fluoroscopic or CT guidance.

CPT/HCPCS	CPT/HCPCS Code Description
62320	Injection(s), of diagnostic or therapeutic substance(s) (eg, 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) (eg, 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 (ie, fluoroscopy or CT)
62322	Injection(s), of diagnostic or therapeutic substance(s) (eg, 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) (eg, 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 (ie, fluoroscopy or CT)
62324	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, 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) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; with imaging guidance (ie, fluoroscopy or CT)
62326	Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (eg, 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) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT)
64400	Injection, anesthetic agent; trigeminal nerve, any division or branch
64405	Injection, anesthetic agent; greater occipital nerve
64408	Injection, anesthetic agent; vagus nerve
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
64435	Injection, anesthetic agent; paracervical (uterine) nerve
64445	Injection, anesthetic agent; sciatic nerve, single

CPT/HCPCS	CPT/HCPCS Code Description
64446	Injection, anesthetic agent; sciatic nerve, continuous infusion by catheter (including catheter placement)
64447	Injection, anesthetic agent; femoral nerve, single
64448	Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement)
64449	Injection, anesthetic agent; lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)
64450	Injection, anesthetic agent; other peripheral nerve or branch
64455	Injection(s), anesthetic agent and/or steroid, plantar common digital nerve(s) (eg, Morton's
64461	Paravertebral block (PVB) (paraspinous block), thoracic; single injection site (includes imaging guidance, when performed)
64462	Paravertebral block (PVB) (paraspinous block), thoracic; second and any additional injection site(s) (includes imaging guidance, when performed) (List separately in addition to code for primary procedure)
64463	Paravertebral block (PVB) (paraspinous block), thoracic; continuous infusion by catheter (includes imaging guidance, when performed)
64479	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level
64480	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional level (List separately in addition to code for primary procedure)
64483	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level
64484	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional level (List separately in addition to code for primary procedure)
64490	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic;
64491	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level (List separately in addition to code for primary procedure)
64492	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s) (List separately in addition to code for primary procedure)
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral;
64494	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level (List separately in addition to code for primary procedure)
64495	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s) (List separately in addition to code for primary procedure)
64505	Injection, anesthetic agent; sphenopalatine ganglion
64510	Injection, anesthetic agent; stellate ganglion (cervical sympathetic)

CPT/HCPCS	CPT/HCPCS Code Description
64517	Injection, anesthetic agent; superior hypogastric plexus
64520	Injection, anesthetic agent; lumbar or thoracic (paravertebral sympathetic)
64530	Injection, anesthetic agent; celiac plexus, with or without radiologic monitoring
64999	Unlisted procedure, nervous system

Obstetrical Anesthesia:
Payment for obstetric anesthesia, when allowable, is reimbursable as the Base unit, plus Time units, plus Modifier units, subject to a maximum cap of 23 units. The maximum of 23 units would apply to labor and a subsequent caesarean section, if necessary, when billed for the same patient.
The following codes apply:

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

Percutaneous Image Guided Procedure
Payment for percutaneous image guided procedures, when allowable, are reimbursable at the ASA rate as published in this payment policy.

The following codes apply:

- 01937: Anesthesia for percutaneous image-guided injection, drainage or aspiration procedures on the spine or spinal cord; cervical or thoracic
- 01938: Anesthesia for percutaneous image-guided injection, drainage or aspiration procedures on the spine or spinal cord; lumbar or sacral
- 01939: Anesthesia for percutaneous image-guided destruction procedures by neurolytic agent on the spine or spinal cord; cervical or thoracic
- 01940: Anesthesia for percutaneous image-guided destruction procedures by neurolytic agent on the spine or spinal cord; lumbar or sacral
- 01941: Anesthesia for percutaneous image-guided neuromodulation or intravertebral procedures (eg, kyphoplasty, vertebroplasty) on the spine or spinal cord; cervical or thoracic
- 01942: Anesthesia for percutaneous image-guided neuromodulation or intravertebral procedures (eg, kyphoplasty, vertebroplasty) on the spine or spinal cord; lumbar or sacral
-

Rationale

A **pre-anesthesia evaluation** by the anesthesiologist when surgery is canceled may be covered at the level of care rendered (e.g., brief or limited visit) as a hospital or office visit.

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

If anesthesiologists are in a **group practice**, one physician member may provide the pre-anesthesia examination and evaluation while another fulfills the other criteria.

Similarly, one physician member of the group may provide post-anesthesia care while another member of the group furnishes the other component parts of the anesthesia service. The medical record must indicate the services furnished and identify the physicians who furnished them. However, only one member of the group is eligible to bill for the entire anesthesia service.

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

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

When **multiple surgical procedures** are performed during a single anesthetic administration, the anesthesia code representing the most complex procedure should be reported. The time reported is the combined total for all procedures.

If **circumstances warrant two anesthesiologists**, documentation should be submitted with the claim. A base value of five units plus time will be allowed for the second anesthesiologist.

Reimbursement Guideline

Blue Shield of California will reference national or regional industry standards, such as Centers for Medicare & Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and MUE (Medically Unlikely Edits) rules, and American Medical Association's (AMA) CPT guidelines, as coding standards and as guidance for payment policy. In claims payment scenarios where CMS and/or CPT reference is lacking or insufficient, the Payment Policy Committee (PPC) may develop customized payment policies that are based on other accepted or analogous industry payment standards and or expert input.

Resources
• **American Medical Association** http://www.ama-assn.org/ama • **Centers for Medicare & Medicaid Services** http://www.cms.gov/

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Payment Policy.

Effective Date	Action	Reason
10/01/2010	New Payment Policy	Medical Policy Committee
10/29/2010	Policy revision with position change	Administrative Review
05/05/2011	Policy revision to align with the July 1, 2011 Provider Manual	Medical Policy Committee
07/11/2011	Administrative Review	Administrative Review
03/30/2012	Modification of CRNA language based on the State of California CRNA Scope of Licensure	Administrative Review
09/20/2013	Policy revision, addition of language for modifiers AD, QY, QK and additional	Payment Policy Review
06/16/2014	Updated CRNA language to reflect change in reimbursement for modifiers and denial of claims without modifiers appended	Payment Policy Review
01/01/2016	Payment policy maintenance	Payment Policy Review
02/01/2017	Formatting	Payment Policy Review
07/08/2017	Policy Revision	Payment Policy Committee
01/25/2018	Policy Maintenance	Payment Policy Committee
08/03/2018	Policy Maintenance	Payment Policy Committee
01/01/2019	Policy updates: • 64508 deleted as of 01/01/2019	Annual Maintenance
01/01/2020	Policy updates: Added and updated terms and definitions • 64402, 64410 and 64413 deleted as of 01/01/2020 • 64999 added new code effective 01/01/2020	Annual Maintenance
01/01/2022	Policy updates: Added and updated terms and definitions • Removed 01935-01936, deleted codes effective 01/01/2022 • Added 01937-01942, new codes effective 01/01/2022	Annual Maintenance

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