BlueCross BlueShield of Arizona
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PRICING GUIDELINES **EFFECTIVE DATE: 05/01/2019**
REVISION DATE: 08/02/2019

Changes: For claims processed on or after 5/1/2019, patient status modifiers P3, P4 and P5 will be treated as informational only.

ANESTHESIA SERVICES PRICING GUIDELINES

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Pricing Guideline must be read in its entirety to determine coverage eligibility, if any.

The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

The section identified as "Pricing" defines criteria to determine how to price anesthesia services using units (time, base and modifier units).

Pricing Guidelines are subject to change as new information becomes available.

Description:

Sedation and analgesia comprise a continuum of states ranging from minimal sedation through general anesthesia. Sedation/anesthesia services include the usual pre-operative and postoperative visits, the anesthesia care during the procedure, the administration of fluids and/or blood and the usual monitoring services (e.g., ECG, temperature, blood pressure, oximetry, capnography and mass spectrometry).

CPT anesthesia service codes 00100 through 01999 (excluding 01953 and 01996) can be used to describe minimal sedation, deep sedation, general anesthesia and monitored anesthesia care services. Reporting of anesthesia services is appropriate when provided by or under the medical supervision of a physician. The anesthesia codes should be used only by physicians not performing the surgical procedures.

CPT codes 99151 – 99153 can be used to describe moderate sedation services administered by the same provider performing the diagnostic or therapeutic service. CPT codes 99155 - 99157 can be used to describe moderate sedation services administered by a different provider other than the provider performing the diagnostic or therapeutic service.

As of 7/1/2018, BCBSAZ no longer recognizes the 2016 Current Procedural Terminology (CPT) Appendix G, "Summary of CPT Codes That Include Moderate (Conscious) Sedation" nor any associated guidelines for submitting these codes.

For claims processed on or after 11/1/2018, BCBSAZ rounds anesthesia time minutes to the "nearest" whole anesthesia time unit, instead of the "next" whole anesthesia time unit.

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ANESTHESIA SERVICES PRICING GUIDELINES (cont.)

Description: (cont.)

Deep Sedation/Analgesia:
A drug-induced *depression of consciousness*. Individual cannot be easily aroused but responds purposefully following repeated or painful stimulation. Ability to independently maintain ventilatory function may be impaired. May require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

General Anesthesia:
A drug-induced *loss of consciousness*. Individual is not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Often requires assistance in maintaining a patent airway and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Minimal Sedation (Anxiolysis):
A *drug-induced state*. Individual responds normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected. Examples include local or topical anesthesia, regional anesthesia, (nerve blocks, spinal and epidural anesthesia), oral sedative or analgesic medication. Local anesthesia numbs just a small area of tissue where a minor procedure is to be done.

Moderate Sedation/Analgesia (Conscious Sedation):
A drug-induced *depression of consciousness*. Individual responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions required to maintain a patent airway and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Monitored Anesthesia Care (MAC):
Anesthesiologist is requested to be present during procedure in case the individual needs some type of anesthesia. Individual may receive a local anesthesia, intravenous analgesia or no anesthesia at all. In all cases, the anesthesiologist monitors vital signs and is available to administer anesthetics or to provide other medical care as appropriate.

Qualifying Circumstances for Anesthesia:
Anesthesia services provided under difficult circumstances, such as extraordinary condition of individual, notable operative conditions and/or unusual risk factors.

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ANESTHESIA SERVICES PRICING GUIDELINES (cont.)

Criteria:

The following table (*Criteria A*) separates the different types of anesthesia and the procedure codes that correlate. The table will chart the eligibility and reimbursement between a provider performing the surgical procedure plus administering the anesthesia (same provider), compared to another provider administering only the anesthesia (different provider).

A. DEEP SEDATION-GENERAL ANESTHESIA / MINIMAL SEDATION / MONITORED ANESTHESIA CARE:

Provider	Deep Sedation / General Anesthesia / Monitored Anesthesia Care [CPT: 00100-01999]	Minimal Sedation [CPT: 64400-64530]
Same provider performing the surgical procedure and administering anesthesia / sedation	[CPT: 00100-01999] **Not Eligible for reimbursement** *(00100-01999 Considered an included service.)*	[CPT: 64400-64530] **Not Eligible for reimbursement** *(64400 - 64530 Considered an incidental service.)*
Different provider (other than the provider performing the procedure)	[CPT: 00100-01999] **Eligible for reimbursement.**	[CPT: 64400-64530] **Not Eligible for reimbursement** *(64400 - 64530 Considered an incidental service.)*

B. Stand By Services:

Anesthesia stand by services are *eligible for reimbursement* with documentation of ALL of the following:

1. Medically necessary percutaneous coronary angioplasty (PTCA)
2. Anesthesia provider is physically present

ANESTHESIA SERVICES PRICING GUIDELINES (cont.)

Criteria: (cont.)

C. Services that are Included in Sedation or Anesthesia Services—FACILITY OR NON-FACILTY Settings:

Refer to the Included Services Pricing Guideline for items that are considered included in office visits, surgeries, sedation or anesthesia services.

The following services are an integral part of the sedation or the anesthesia and are considered included when rendered in EITHER a FACILITY or NON-FACILITY setting and are ***not eligible for separate reimbursement.*** These services should not be reported separately:

1. DME items or supplies that are integral to the administration of anesthesia and the transportation of those items to the office or facility settings (e.g., nasopharyngeal airway, backup power source, external defibrillator, wheeled cart)
2. Pre-operative and postoperative assessment of the individual receiving sedation or anesthesia (not included in intra-service time*)
3. Establishment of IV access and administration of fluids and/or blood products incident to the procedure
4. Administration of the anesthetic or analgesic agent(s)
5. Maintenance of sedation
6. Interpretation and reporting of noninvasive monitoring during sedation (e.g., ECG/EKG, temperature, blood pressure, oximetry, capnography, mass spectrometry, EEG and BIS EEG)
7. Field avoidance (i.e., anesthesiologist does not have direct access to the patient's airway during surgery)
8. Position change (i.e., any procedure requiring a position other than supine or lithotomy)

* Intra-service time begins when medication is given to start the sedation and requires continuous face-to-face attendance and ends when the physician is no longer in attendance.

D. Services that maybe Eligible for Separate Reimbursement in a NON FACILITY Setting ONLY:

The following services when rendered in a NON-FACILITY setting may be ***eligible for separate reimbursement***:

1. General anesthetic supplies (e.g., IV tubing, supplies for external infusion pump)
2. DME items related to administration of oxygen (e.g., oxygen, liquid oxygen system rental, regulator)
3. General anesthetic or analgesic agent(s)

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ANESTHESIA SERVICES PRICING GUIDELINES (cont.)

Criteria: (cont.)

E. Anesthesia Modifiers:

For anesthesia services ***to be eligible for separate reimbursement***, one of the anesthesia modifiers listed below (47, AA, AD, QK, QS*, QX, QY and QZ) must be appended to the anesthesia procedure code (00100 – 01999).

- Modifier 47: Anesthesia by surgeon.

  NOTE: Modifier 47 is ***only eligible for separate reimbursement for provider specialties of "oral surgery" and/or" oral & maxillofacial surgery"***, otherwise anesthesia services are considered included in the provider's reimbursement for the diagnostic or therapeutic procedure.

- Modifier AA: *(Anesthesiologist modifier)* Anesthesia services performed personally by anesthesiologist.

- Modifier AD: *(Anesthesiologist modifier)* Medical supervision by a physician: more than 4 concurrent anesthesia procedures.

- Modifier QK: *(Anesthesiologist modifier)* Medical direction of 2, 3 or 4 concurrent anesthesia procedures involving qualified individuals.

- Modifier QS*: Monitored anesthesia care service.

  (Anesthesiologist: If personally performed the anesthesia service to the patient and also administered Monitored Anesthesia Care (MAC), the modifiers used would be AA and QS.)

  (CRNA: If CRNA is without medical directions by an anesthesiologist and bills with the modifier QZ and personally performed the anesthesia service to the patient and also administered Monitored Anesthesia Care (MAC), the modifiers used would be QZ and QS.)

  NOTE**: ***For anesthesia services appended with a modifier QS to be eligible for separate reimbursement, an additional anesthesia modifier (AA, AD, QK, QX, QY or QZ) is required.

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ANESTHESIA SERVICES PRICING GUIDELINES (cont.)

Criteria: (cont.)

E. Anesthesia Modifiers: (cont.)

- Modifier QX: *(CRNA modifier)* CRNA service; with medical direction by an anesthesiologist.
- Modifier QY: *(Anesthesiologist modifier)* Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist.
- Modifier QZ: *(CRNA modifier)* CRNA service: without medical direction by an anesthesiologist.

NOTE: Possible Anesthesia Modifier Reimbursement Reduction
To verify if reimbursement reduction apply to any of the above listed anesthesia modifiers, access the "Modifier Pricing Action" listing located in the secure provider portal at azblue.com/providers in "Provider Resources > Claim Pricing > Modifier Pricing Action Listing". If modifier not listed, no reduction applies.

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ANESTHESIA SERVICES PRICING GUIDELINES (cont.)

Criteria: (cont.)

F. Billing Criteria of Anesthesia Modifiers:

The following criterion explains how Anesthesiologists and CRNAs (certified registered nurse anesthetist) should bill BCBSAZ for services:

Anesthesiologist working independently:

- Submit the claim under the Anesthesiologist's NPI number
- Include modifier AA

CRNA that is medically directed by an Anesthesiologist:

- Separate claims should be submitted by each practitioner (CRNA and anesthesiologist) using his/her own NPI number and the appropriate modifier(s)
- Both Anesthesiologist and CRNA should submit the same CPT code(s) and time on both their separate claims.
- Following modifiers should be noted on the claim for either Anesthesiologist or CRNA:
  - Modifiers for **Anesthesiologist** *when directing/supervising* CRNA(s):
    - ✓ AA and QY in conjunction: If medically directing one CRNA
    - ✓ AA and QK in conjunction: If medically directing two – four concurrent anesthesia procedures
    - ✓ AA and AD in conjunction: If supervising more than four anesthesia procedures
  - Modifier for **CRNA** *being directed by anesthesiologist*: QX
  - Modifier for **CRNA** that *work independently* (without anesthesiologist): QZ

NOTE: To verify if reimbursement reduction apply to any of the above listed anesthesia modifiers, access the "Modifier Pricing Action" listing located in the secure provider portal at azblue.com/providers in "Provider Resources > Claim Pricing > Modifier Pricing Action Listing". If modifier not listed, no reduction applies.

Changes: For claims processed on or after 5/1/2019, patient status modifiers P3, P4 and P5 will be treated as informational only.

ANESTHESIA SERVICES PRICING GUIDELINES (cont.)

Pricing:

The following anesthesia pricing methodology is used to reimburse anesthesia services (00100-01999, except for 01953 and 01996. Refer to note in this section):

Determining Anesthesia Units:

Reimbursement methodology reflects total units multiplied by anesthesia fee:

Base Units + Time Units = Total Units

Base Units: The number of anesthesia base units will depend on the anesthesia CPT Code being submitted. For appropriate base units, logon to the secure provider portal at azblue.com/provider and access the "Anesthesia Base Units" document using the following path: "Provider Resources > Claim Pricing > Anesthesia Base Units"

Time Units: Anesthesia time units are derived by the amount of time the anesthetist administers the anesthesia face-to-face to the patient. Each 15-minute increment represents 1 time unit of service.

Claims processed prior to 11/1/2018: Any additional time over the 15-minute increment would add one additional time unit. (Round up to the "next" whole time unit.) Examples:

Process Prior 11/1/2018	
Minutes	Units
1 - 15	1
16 - 30	2
31 - 45	3
46 - 60	4

Claims processed on 11/1/2018 and after: Fractions of the 15-minute increment must be over 7.50 minutes to allow for an additional time unit. (Round to the "nearest" whole time unit.) Examples:

Process on 11/1/2018 and After	
Minutes	Units
1 - 7	0
8 - 22	1
23 - 37	2
38 - 52	3
53 - 67	4

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ANESTHESIA SERVICES PRICING GUIDELINES (cont.)

Pricing: (cont.)

The following anesthesia pricing methodology is used to reimburse anesthesia services (00100-01999, except for 01953 and 01996. Refer to note below): (cont.)

Determining Anesthesia Units: (cont.)

Time Units: (cont.)

Providers are required to report the actual anesthesia time in minutes on the CMS 1500 claim form in field 24G. In addition, providers are required to bill the number of anesthesia units to accurately reflect the actual time the anesthesia was administered to patient face-to-face.

NOTE: For maternity epidural anesthesia, the maximum anesthesia time units is 24 Time Units per encounter (*i.e., services from the same provider for the same patient and date of service*). Providers are required to bill the number of maternity epidural anesthesia time units to accurately reflect the actual time the epidural was administered.

(*For maternity epidural anesthesia pricing examples, refer to "Maternity Epidural Anesthesia Pricing Guideline" located in* azblue.com/provider *using the following path: "Provider Resources > Claim Pricing > Maternity Epidural Anesthesia Pricing Guideline")*

NOTE: Per ASA-RVG®, CPT 01953 and 01996 should not be submitted as time-base services and thus are not considered anesthesia services and will not reimburse per the above anesthesia pricing formula (which is based on time units). CPT 01953 and 01996 will reimburse using the Fee Schedule multiplied by the number of service units reported.

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ANESTHESIA SERVICES PRICING GUIDELINES (cont.)

Pricing: (cont.)

Pricing Example 1: (Anesthesia Time evenly divisible by 15 minutes)

Anesthesia Time: 12:00 – 6:00
(*6 hours = 360 minutes divided by 15 minutes = 24 Time Units*)

Procedure Code: 00820 (5 Base Units)

Base Units	+	Time Units	=	Total Units
5		24		29

Pricing Example 2: (Anesthesia Time not evenly divisible by 15 minutes)

Anesthesia Time: 12:00 – 6:05
(*6 hours & 5 minutes = 365 minutes divided by 15 minutes = 24.33 Time Units =24 Time Units*)

Procedure Code: 00820 (5 Base Units)

Base Units	+	Time Units	=	Total Units
5		24		29

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ANESTHESIA SERVICES PRICING GUIDELINES (cont.)

Coding Referenced:

CPT: 00100 – 01999, 64400 – 64530, 95999, 99100, 99116, 99135, 99140, 99151, 99152, 99153, 99155, 99156, 99157, 99360
Appendix G

HCPCS: G0104, G0105, G0106, G0120, G0121, G0297

Anesthesia Modifiers: 47, AA, AD, QK, QS, QX, QY, QZ

Resources:

1. American Medical Association. Current Procedural Terminology (CPT®)
2. Health Care Procedure Coding System (HCPCS®)
3. Centers for Medicare & Medicaid Services (CMS®)