June 4, 2007
S-07-07

The Blue Shield Report is published by the professional relations department of Blue
Cross and Blue Shield of Kansas.

OUR WEB ADDRESS:
http://www.bcbsks.com

Dorothy Byrd
Communications Coordinator

Questions:
Contact your professional relations representative, or the
professional relations hotline in Topeka at 785-291-4135 or
1-800-432-3587.

Acknowledgement:
Current Procedural Terminology® (CPT) is copyright 2006 American
Medical Association. All Rights Reserved. No Fee schedules, basic
units, relative values or related listings are included in CPT. The
AMA assumes no liability for the data contained herein. Applicable
FARS/DFARS Restrictions Apply to Government Use.

Anesthesia Coverage for Gastrointestinal Endoscopies

This newsletter clarifies all previous communications regarding anesthesia coverage for gastrointestinal endoscopies. Blue Cross
and Blue Shield of Kansas (BCBSKS) reimburses anesthesia for
gastrointestinal endoscopies at several levels. Please note the place
of service, since it impacts payment levels.

Unusual Anesthesia

Claims for this level should be billed using codes 00740 or
00810 with modifier 23 describing unusual anesthesia when
performed only in an inpatient, outpatient or ASC setting.
BCBSKS will only reimburse CRNAs or a physician capable
of starting anesthesia. Reimbursement will be the provider's
charge up to a maximum of $307.50.

Moderate Sedation

When moderate conscious sedation is utilized in a facility, the
service will be reimbursed separately when it is billed by a
CRNA or a physician capable of starting anesthesiology, using
the appropriate CPT codes (99148-99150).

Moderate sedation done in an office setting is always considered
content of service to the office procedure rendered by the
performing provider and will be denied as a provider write-off.

Monitored Anesthesia

BCBSKS will make payment to an anesthesiologist or CRNA
for monitored anesthesia in those limited situations where the
patient’s condition is considered “at risk” and the use of
monitored anesthesia care or general anesthesia is required to
adequately and safely perform the procedure. If you have a
patient who meets one of the criteria listed below and receives
monitored or general anesthesia, you will need to bill the
appropriate CPT anesthesia code (00740, 00810, 01920, or
01922) and ICD-9 diagnosis codes or modifiers that are
indicated below. When monitored anesthesia care is performed, modifier QS should always be reported in addition to the CPT anesthesia code along with the appropriate diagnosis codes. These situations will be reimbursed using standard anesthesia reimbursement methodology.

The following conditions are considered covered:

- **Supported by Diagnosis Code:**
  - Pregnancy: V22.0-V22.9, 633.01, 633.81-633.91, 640.0-645.23, 646.10-649.64, or 650-659.93
  - Opiate, alcohol, or sedative dependency: 303.00-303.93, 304.00-304.03, 304.10-304.13, 304.70-304.73
  - Sleep apnea: 327.20, 327.21, 327.23, 327.25-327.29, 780.53, 780.57

- **Age of Patient:** If the patient is 70 years of age or older or 12 years of age or younger, the system will pay the service based on birth date information within our system.

- **Physical Status Modifiers:** Medical necessity is met if the patient has an increased risk of complication due to severe co-morbidity according to the ASA Physical Status modifiers P3, P4 or P5 and it is reported on the claim through the use of these modifiers. (These modifiers are only recognized by BCBSKS for the purpose of determining medical necessity and coverage of the services in question. Use of these modifiers will not increase the overall reimbursement of the service.)

  **NOTE:** Medical record documentation must support the medical necessity of the anesthesia service and care provided. This documentation must be provided if and when requested.

- **Other considerations:** When other medical conditions (such as morbid obesity, behavioral, dysmorphic and neurological conditions) increase the risk of the patient and monitored or general anesthesia is required, please add modifier 22 to the CPT anesthesia code and submit medical records for coverage consideration.

If the patient's medical condition or risk factors are not listed above and monitored sedation is billed, it will be denied not medically necessary as a provider write-off.