2020 Policy Memo 12

Anesthesia

BlueCross BlueShield Kansas

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I. Description

Anesthesia services consist of the administration of an agent in one of the following types of anesthesia:

A. General anesthesia – loss of ability to perceive pain associated with loss of consciousness produced by intravenous infusion of drugs or inhalation of anesthetic agents.
B. Deep sedation/analgesia – drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation.
C. Moderate sedation (conscious sedation) – drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation.
D. Regional anesthesia – use of local anesthetic solutions to produce circumscribed areas of loss of sensation. This includes nerve blocks, spinal, epidural, and field blocks. Epidural anesthesia is produced by injection of local anesthetic solution into the peridural space.

NOTE – Anesthesia provided in an office setting is considered content of service and not reimbursed separately. The provider cannot require the patient to sign a waiver or bill the patient for this service.

II. Time of Administration

Anesthesia time begins with the initial administration of anesthetic agents by the anesthetist/anesthesiologist and ends when the anesthetist/anesthesiologist is no longer in personal attendance. The time of anesthesia administration and the CPT anesthesia codes are required on all claims to ensure proper payment.

III. Content of Services within Usual Anesthesia Fee

The usual professional charge for anesthesia includes the following services:

A. Preoperative or postoperative administration and monitoring of anesthetic or analgesia administration.
B. Administration of drugs, fluids, or blood incidental to the anesthesia.
C. Preoperative and postoperative monitoring and/or visits to the patient (including consultations).
D. Monitoring of sedation for cardiac catheterizations and PTCAs is done by the cardiologist and facility personnel. Therefore, separate reimbursement is not provided. If intraoperative monitoring is required and performed during a surgery, Blue Cross and Blue Shield of Kansas, Inc. (BCBSKS) will content the service into the all-inclusive surgical MAP.
E. Local Infiltration or Topical Application of Anesthesia.

No additional fee is acknowledged for these services or supplies. The procedures are considered content of service of the surgical or anesthetic procedure.

IV. Surgical Procedures and Nerve Blocks Performed by the Same Anesthesia Provider

Surgical procedure(s) (e.g., arterial & CVP lines) billed with nerve blocks will be paid according to multiple procedure guidelines at full for the procedure with the greatest value and all others are paid at one half.

V. Method of Determining the Maximum Allowable Payment (MAP)

A. PROFESSIONAL ALLOWANCES

Professional allowances for general anesthesia are determined as follows:

1. Anesthesia base points of the CPT/American Society of Anesthesiologists (ASA) codes, plus
2. One point per each 15 minutes of administration.
   NOTE – The above are multiplied by the BCBSKS anesthesia conversion factor.

B. ANESTHESIA FOR MULTIPLE SURGICAL PROCEDURES

Allowance determined by:

1. Using the CPT code with the highest base value allowed.
2. Payment of one unit of time per 15 minutes administration.

VI. Related Policies

A. UNUSUAL CASES

When the condition of the patient relative to the surgical procedure to be performed is such as to imply an unusual risk, consideration of an unusual fee may be provided. In such cases, it is necessary to use Modifier 22 and send medical information that will substantiate the case and document direct attendance. It is acknowledged that unusual detention with the patient is eligible for additional time charges. Contracting providers agree to accept the review process determination in such cases.

B. REGIONAL ANESTHESIA

1. When administered by the surgeon or assistant surgeon, payment may be allowed. However, if an anesthesia provider monitors the patient following the regional block, the surgeon or assistant surgeon relinquishes the right to bill for the regional block.
2. A claim for epidural infusion for pain management will be subject to the review process before payment.
   a. If the epidural catheter is placed for the purpose of anesthesia and remains in place for postoperative pain management or local anesthetics, placement of the catheter will be considered content of service of the anesthesia.
   b. If the epidural catheter is placed solely for postoperative purposes (i.e., postoperative anesthetic or pain control), even if general anesthesia or other than epidural is performed, the catheter placement will be paid.
   c. Daily hospital management of epidural drug administration by an anesthesia provider may be paid when either options a. or b. apply. However, if the pain management is accomplished by the surgeon, the pain management is considered content of the service for the surgeon.
3. OB Epidural Guidelines
   a. Epidural placement should be billed separately and reimbursed under the appropriate placement CPT code. The time for the placement of the epidural should NOT be included in total time of the monitoring/delivery anesthesia.
   b. Monitoring and delivery anesthesia will be reimbursed under the appropriate CPT neuraxial labor analgesia/anesthesia codes for vaginal and cesarean deliveries.

BCBSKS will reimburse one unit for every hour of monitoring for vaginal deliveries and one unit for every 15 minutes for cesarean deliveries.

c. Anesthesia time should be reported as total minutes.
d. Anesthesia monitoring concludes at time of delivery for vaginal deliveries.
e. For cesarean deliveries, anesthesia monitoring concludes when patient is transferred to the post-anesthesia care unit/recovery room.

4. Nerve blocks administered on the same day as an anesthesia service will be paid at 50 percent and the anesthesia service paid in full.

C. MONITORED ANESTHESIA SERVICES

Monitoring of sedation by an anesthesia provider for CT scans, MRIs, cardiac catheterizations, and PTCAs is generally considered not medically necessary. BCBSKS will allow payment for inpatient or outpatient facility services when provided for other procedures when billed by an anesthesia provider capable of initiating general anesthesia should it be needed.

Documentation must support the necessity of the anesthesia service and care provided. BCBSKS will monitor the appropriate use of the guidelines.

D. MODERATE (CONSCIOUS) SEDATION

CPT defines moderate sedation as a drug induced depression of consciousness during which patients respond purposefully to verbal commands, whether 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.

When provided in an inpatient or outpatient facility, BCBSKS will allow payment for medically necessary moderate sedation to an anesthesia provider**,** other than the provider of the primary service, who is authorized under state law to administer general anesthesia. Moderate sedation, when performed in an office setting, is considered content of service to the office procedure rendered by the rendering provider and will be denied as a provider write-off.

Documentation must support the necessity of the anesthesia service and care provided. BCBSKS will monitor the appropriate use of the guidelines.

E. MEDICAL DIRECTION

The medical direction or supervision of CRNAs is not a separately reimbursable service. BCBSKS will only reimburse one provider for an anesthesia procedure.

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