

Anthem Blue Cross and Blue Shield | Serving Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect, and Indiana PathWays for Aging

Reimbursement Policy	
Subject: Professional Anesthesia Services	
Policy Number: G-07018	Policy Section: Anesthesia
Last Approval Date: 06/26/2024	Effective Date: 06/26/2024

**** Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to <https://providers.anthem.com/in>. ****

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member's benefit plan. The determination that a service, procedure, or item is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

Ensure that you use proper billing and submission guidelines, including industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Providers who are contracted with Anthem Blue Cross and Blue Shield to serve Hoosier Healthwise, Healthy Indiana Plan, Hoosier Care Connect, and Indiana PathWays for Aging through an accountable care organization (ACO), participating medical group (PMG) or Independent Physician Association (IPA) are to follow guidelines and practices of the group. This includes but is not limited to authorization, covered benefits and services, and claims submittal. If you have questions, please contact your group administrator or your Anthem network representative.

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Policy

Anthem allows reimbursement of anesthesia services rendered by professional providers for covered members unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

Reimbursement is based upon:

- The reimbursement formula for the allowance and time increments in accordance with CMS for Healthy Indiana Plan and state guidelines for Hoosier Healthwise.
- Proper use of applicable modifiers.

Providers must report anesthesia services in minutes. Anesthesia claims submitted with an indicator other than minutes may be rejected or denied. Start and stop times must be documented in the member's medical record. Anesthesia time starts with the preparation of the member for administration of anesthesia and stops when the anesthesia provider is no longer in personal and continuous attendance. The reimbursement formula for anesthesia allowance is based on CMS guidelines.

Anesthesia modifiers

Anesthesia modifiers are appended to the applicable procedure code to indicate the specific anesthesia service or who performed the service. Modifiers identifying who performed the anesthesia service must be billed in the primary modifier field to receive appropriate reimbursement. Additional or reduced payment for modifiers is based on state requirements, as applicable. If there is no state requirement, Anthem will default to the following CMS guidelines. Claims submitted for anesthesiology services without the appropriate modifier will be denied. Please review the link below for reimbursement information for specific anesthesia modifiers.

Anthem allows additional reimbursement for physical status modifiers:

- Modifier P3: A patient with severe systemic disease — allows additional reimbursement of one (1) time unit.
- Modifier P4: A patient with severe systemic disease that is a constant threat to life — allows additional reimbursement of two (2) time units.
- Modifier P5: A moribund patient who is not expected to survive without the operation — allows additional reimbursement of three (3) time units.

Certified registered nurse anesthetist (CRNA) modifiers

Services performed by a CRNA must always include the applicable CRNA modifier to denote medically directed or non-medically directed care.

Multiple anesthesia procedures

Anthem allows reimbursement for professional anesthesia services during multiple procedures. Reimbursement is based on the anesthesia procedure with the highest base unit value and the overall time of all anesthesia procedures.

Obstetrical anesthesia

Anthem allows reimbursement for professional neuraxial epidural anesthesia services provided in conjunction with labor and delivery by either the delivering physician or a

qualified provider other than the delivering physician based on the time the provider is physically present with the member.

Reimbursement is based on one of the following:

- For the delivering physician — based on a flat rate or fee schedule using the surgical CPT pain management codes for epidural analgesia.
- For a qualified provider other than the delivering physician — based on:
 - The allowance calculation.
 - The inclusion of catheter insertion and anesthesia administration.
- Time units for neuraxial epidural anesthesia claims are reimbursed as follows:
 - One unit for each 15 minutes of time for the first 60 minutes
 - One unit for each additional 60 minutes of time

Services provided in conjunction with anesthesia

Anthem allows separate reimbursement for the following services provided in conjunction with the anesthesia procedure or as a separate service:

- Swan-Ganz catheter insertion
- Central venous pressure line insertion
- Intra-arterial lines
- Emergency intubation (must be provided in conjunction with the anesthesia procedure to be considered for reimbursement)
- Critical care visits
- Transesophageal echocardiography

Note: Reimbursement is based on the applicable fee schedule or contracted/negotiated rate with no reporting of time.

Nonreimbursable

Anthem does not reimburse for:

- Anesthesia consultations on the same date as surgery or the day prior to surgery if part of the preoperative assessment.
- Anesthesia services performed for non-covered procedures, including services considered not medically necessary, experimental, and/or investigational.
- Anesthesia services by the provider performing the basic procedure, except for a delivering physician providing continuous epidural analgesia.
- Local anesthesia considered incidental to the surgical procedure.
- Standby anesthesia services.

Reimbursable

Anthem allows one additional base unit for anesthesia services for a member younger than 1 year old or older than 70 years old.

Related Coding		
Modifiers	Description	Comments
AA	Anesthesia services personally performed by the anesthesiologist	Informational

AD	Medical supervision by a physician: more than four (4) concurrent anesthesia procedures	Informational
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals	Reimbursed at 50% of allowance. Reimbursement is based on 50% of the applicable fee schedule or contracted/negotiated amount
QX	Qualified nonphysician anesthetist with medical direction by a physician	Reimbursed at 50% of the applicable fee schedule or contracted/negotiated amount
QZ	CRNA without medical direction by a physician	Reimbursed at 100% of the applicable fee schedule or contracted/negotiated amount
23	Denotes a procedure that must be done under general anesthesia due to unusual circumstances although normally done under local or no anesthesia	Informational
47	Denotes regional or general anesthesia services provided by the surgeon performing the medical procedure. We do not allow reimbursement of anesthesia services by the provider performing the medical procedure (other than obstetrical — see Obstetrical Anesthesia section of this policy); therefore, it is not appropriate to bill modifier 47 with anesthesia services	Informational

Policy History	
06/26/2024	Update due to regulatory directive: added allows additional reimbursement for physical status modifiers; updated modifiers AA, AD, 23, and 47 as informational; removed <i>modifier QY</i>
06/26/2024	Update due to regulatory directive: removed <i>reimburses modifier QZ at 80% of the allowed amount</i>
02/16/2024	Update due to regulatory directive: HHC and HHW follow reimbursement percentages same as HIP, reviewed 02/16/2024, and effective 01/01/2024
06/13/2023	Review approved and effective: policy template updated; added to allow one additional base unit for anesthesia services for a member younger than 1 year old or older than 70 years old

11/06/2020	Review approved and effective: minor administrative updates to policy body; updates to distinguish between reimbursement allowance for Hoosier Healthwise and Healthy Indiana Plan; added anesthesia modifier grid
06/17/2019	Update due to regulatory directive: update to allow time units for neuraxial epidural anesthesia and clarify language for CRNA services
01/01/2019	Update due to regulatory directive: Modifier QY is not eligible for reimbursement.
10/03/2018	Review approved 10/03/2018 and effective 11/01/2019
01/03/2017	Review approved and effective
02/01/2015	Initial approval and effective

References and Research Materials	
This policy has been developed through consideration of the following:	
<ul style="list-style-type: none"> • American Society of Anesthesiologists • CMS • Optum EncoderPro 2023 • State contract • State Medicaid 	

Definitions	
Anesthesia	Refers to the drugs or substances that cause a loss of consciousness or sensitivity to pain.
Base unit	The relative value unit associated with each anesthesia procedure code as assigned by CMS.
Time unit	An increment of fifteen (15) minutes where each 15-minute increment constitutes one (1) time unit.
Conversion factor	A geographic-specific amount that varies by the locality where the anesthesia is administered.
General Reimbursement Policy Definitions	

Related Policies and Materials	
Maternity Services	
Modifier Usage	
Reduced and Discontinued Services	
Scope of Practice	