Reimbursement Policy

Subject: **Professional Anesthesia Services**	
Policy Number: **G-07018**	Policy Section: **Anesthesia**
Last Approval Date: **06/13/2023**	Effective Date: **11/06/2020**

**** 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/ca.** ****

Disclaimer

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

You must follow proper billing and submission guidelines. You are required to use 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, Anthem 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These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. Anthem strives 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

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policies when necessary. When there is an update, we will publish the most current policy to the website.

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 guidelines.
- 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 attachment below for reimbursement information for specific anesthesia modifiers.

Anthem allows the use of Modifier 99.

Anthem allows additional reimbursement for physical status modifiers:

- Modifier P3: a patient with severe systemic disease — increases unit value by two.
- Modifier P4: a patient with severe systemic disease that is a constant threat to life — increases unit value by two.
- Modifier P5: a moribund patient who is not expected to survive without the operation — increase unit value by four.

Anthem does not allow the use of Modifier AD or Modifier 23.

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 for up to 300 minutes 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. Providers must submit additional documentation upon dispute for consideration of reimbursement of time in excess of 300 minutes. 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.

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:

- Use of patient status modifiers or qualifying circumstances codes denoting additional complexity levels.
- Anesthesia consultations on the same date as surgery or the day prior to surgery if part of the preoperative assessment.
- Anesthesia services performed for noncovered 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.

Related Coding	
Code	**Description**
Anesthesia Modifiers	**Anesthesia Modifiers**

Policy History	
06/13/2023	Review approved: policy template updated
11/06/2020	Review approved and effective: minor administrative updates to policy body, added anesthesia modifier grid and reimbursement formulas
10/03/2018	Review approved 10/03/2018 and effective 09/01/2019: Anesthesia modifiers language updated
05/30/2007	Initial approval 05/30/2007 and effective 07/01/2007

References and Research Materials

This policy has been developed through consideration of the following:

- 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 15 minutes where each 15-minute increment constitutes one 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