	Reimbursement Policy	
Subject: Professional Anesthesia Services		
Effective Date: **11/06/20**	Committee Approval Obtained: **11/06/20**	Section: **Anesthesia**

*****The most current version of our reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to **https://providers.healthybluela.com**.*****

These 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 Healthy Blue Dual Advantage (HMO D-SNP) member's 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 CPT® codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to participating providers and facilities; a noncontracting provider who accepts Medicare assignment will be reimbursed for services according to the original Medicare reimbursement rates.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Healthy Blue Dual Advantage may:

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

Healthy Blue Dual Advantage reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements. System logic or set up may prevent the loading of policies into the claims platforms in the same manner as described; however, Healthy Blue Dual Advantage strives to minimize these variations.

Healthy Blue Dual Advantage reserves the right to review and revise its policies periodically when necessary. When there is an update, we will publish the most current policy to the website.

Policy	Healthy Blue Dual Advantage 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. • 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. For additional or reduced payment for modifiers, Healthy Blue Dual Advantage will default to the following CMS guidelines. Claims submitted for anesthesiology services without the appropriate modifier will be denied. Please review the links below for reimbursement information for specific anesthesia modifiers.

Multiple Anesthesia Procedures
Healthy Blue Dual Advantage 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
Healthy Blue Dual Advantage 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
Healthy Blue Dual Advantage allows separate reimbursement for the following services provided in conjunction with the anesthesia procedure or as a separate service. Reimbursement is based on the applicable fee schedule or contracted/negotiated rate with no reporting of time.

- 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

	Nonreimbursable Healthy Blue Dual Advantage 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.
History	• Biennial review approved **11/06/20**: minor administrative updates; added anesthesia modifier grid • Initial approval and effective date **01/01/20**
References and Research Materials	This policy has been developed through consideration of the following: • CMS • State contract • Healthy Blue contract(s) • American Society of Anesthesiologists
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	• Maternity Services • Modifier Usage • Reduced and Discontinued Services • Scope of Practice
Related Materials	• Anesthesia Modifiers

Anesthesia Modifiers

This table is provided as an informational tool to identify anesthesia modifiers and associated reimbursement rules.

Modifiers	Description	Comments
AA	Anesthesia services personally performed by the anesthesiologist	Reimbursed at 100% of applicable fee schedule or contracted/negotiated rate
AD	Medical supervision by a physician: more than our four concurrent anesthesia procedures	Reimbursed at 100% of the applicable fee schedule or contracted/negotiated rate for up to three base units for anesthesiologists
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
QY	Anesthesiologist medically directs one CRNA — reimbursement is based on 50% of the applicable fee schedule or contracted/negotiated amount	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	Reimbursed at 100 % of the applicable fee schedule or contracted/negotiated rate of the procedure; does not increase or decrease reimbursement; it substantiates billing anesthesia associated with the procedure in cases where anesthesia is not usually appropriate
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	No additional reimbursement is allowed for 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