



IMPORTANT NOTICE REGARDING NEW ANESTHESIA BILLING GUIDELINES AND REIMBURSEMENT PROCEDURES

February 2010

This notice will serve as an update to the November 2008 Anesthesia Billing Guidelines and Reimbursement Procedures notification. Please review this document and submit claims according to the revised guidelines. **Important update regarding Moderate (Conscious) Sedation on pages 4 and 5.**

Medical Policies

Mountain State Blue Cross Blue Shield Medical Policies may be accessed on website, www.msbcbs.com. Click the “Provider” tab, then “Medical Policy”. Please note the different links for Mountain State Medical Policies, Medicare Advantage Medical Policies and Medicare Advantage Gap Fill Medical Policies.

Anesthesia Procedure Codes

When billing anesthesia services, please use the anesthesia procedure codes (00100-01999) and appropriate modifiers to report the administration of anesthesia.

If you report a “not otherwise specified” or “not otherwise classified” anesthesia service, include a complete description of the services performed. Mountain State cannot accept the terminology of an anesthesia procedure code as a description of the service or surgery performed. You must describe the actual service or surgery being performed, or advise of the related surgical code; otherwise, your claim may be rejected.

Here are some examples of how to report “not otherwise specified” or “not otherwise classified” anesthesia services:

24.	A	B	C	D	E	F	G	H	I	J	K
	DATES OF SERVICE	Place of service	Type of service	PROCEEDURE SERVICE OR SUPPLY (If applicable, include CPT/HCPCS code)	DIAGNOSIS CODE	CHARGES	DAYS OR UNITS	EPDST Family Plan	EMG	COB	RESERVED FOR LOCAL USE
	FROM MM DD YY TO MM DD YY			CPT/HCPCS MODIFIER							
	07012005 07012005			00880 AA			65				
				Thrombendarterectomy with or without patchgraft,							

24.	A	B	C	D	E	F	G	H	I	J	K
	DATES OF SERVICE	Place of service	Type of service	PROCEEDURE SERVICE OR SUPPLY (If applicable, include CPT/HCPCS code)	DIAGNOSIS CODE	CHARGES	DAYS OR UNITS	EPDST Family Plan	EMG	COB	RESERVED FOR LOCAL USE
	FROM MM DD YY TO MM DD YY			CPT/HCPCS MODIFIER							
	07012005 07012005			00880 AA 1			65				
				(35355)							

Electronic billers: You must report narratives (complete description of the services performed) in the appropriate NOC narrative field of the electronic format you are utilizing.

Time Units

Anesthesia time begins when the physician or CRNA is first in attendance with the patient for the purpose of creating the anesthetic state. Anesthesia time ends when the physician or CRNA is no longer in attendance. You must document this time in the anesthesia record.

Anesthesia services not requiring time reporting are reimbursed under the applicable RBRVS fee schedule.

Report total anesthesia time as minutes, not start and stop time: Mountain State will convert total minutes to time units. Mountain State determines the time units on the basis of one time unit for each 15 minute segment.

Electronic billers: Report minutes.

Paper billers: Report total anesthesia time as minutes in block 24G on the CMS-1500 claim form.

Modifiers

Please report the appropriate anesthesia modifier to denote whether the service was personally performed, medically directed or medically supervised:

AA - Anesthesia services performed personally by anesthesiologist;

AD - Medical supervision by a physician: more than four concurrent anesthesia procedures;

G8 - Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedures;

G9 - Monitored anesthesia care for patient who has a history of severe cardiopulmonary condition;

GC - This service has been performed in part by a resident under the direction of a teaching physician;

QK - Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals;

QS - Monitored anesthesia care service;

QX - CRNA service; with medical direction by a physician;

QY - Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist;

QZ - CRNA service without medical direction by a physician;

Qualifying Circumstances

99100 – Anesthesia for patient of extreme age, younger than 1 year and older than 70.

99116 – Anesthesia complicated by utilization of total body hypothermia

99135 – Anesthesia complicated by utilization of controlled hypotension

99140 – Anesthesia complicated by emergency conditions (specify)

Qualifying circumstances CPT codes 99100-99140 represent the provision of anesthesia services under particularly difficult circumstances that necessitate the skills of a physician beyond those usually required.

You must report the appropriate qualifying circumstances code **in addition to** the anesthesia CPT code on the same claim. **Do not report units. (This applies to both paper and electronically billed claims.) You must also report the applicable anesthesia modifier with the qualifying circumstance code.**

Exception: You can report physical status with the applicable modifier. Report this modifier only in conjunction with the appropriate anesthesia procedure code (00100-01999):

Modifier	Description	Modifying units
P1	A normal healthy patient (Physical status 1)	0
P2	A patient with mild systemic disease (Physical status 2)	0
P3	A patient with severe systemic disease (Physical status 3)	1
P4	A patient with severe systemic disease that is a constant threat to life (Physical status 4)	2
P5	A moribund patient who is not expected to survive without the operation (Physical status 5)	3
P6	A declared brain-dead patient whose organs are being removed for donor purposes (Physical status 6)	0

Anesthesia Related To Obstetrical Care

This may include any of the following procedures:

- 01960 - anesthesia for vaginal delivery only
- 01961 - anesthesia for cesarean delivery only
- 01962 - anesthesia for urgent hysterectomy following delivery
- 01967- neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)
- 01968 - anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia
- 01969 - anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia

01968 and 01969 are add-on codes and they cannot be billed as a primary procedure.

Code 01967 should be reported for epidural anesthesia care provided either: (1) during labor only; or (2) during labor and vaginal delivery. Total time reported should reflect actual time in personal attendance with the patient. Payment for code 01967 will be based on the appropriate number of base units (BU) and total time units (TU) in attendance with the patient, either during labor only or during labor with vaginal delivery.

When procedure code 01967 is reported in conjunction with either 01968 or 01969, the base units and time units for each code should be reimbursed. Time units reported should reflect actual time in personal attendance. **Payment for continuous epidurals will be reimbursed up to a maximum of 15 time units for 01967, 01960, 01961 and for the combined time billed with 01967 and 01968. (A maximum of eight time units will apply to the West Virginia Small Business Plan.)**

Medical Direction of an Employed CRNA

Services performed by an employed CRNA require medical direction or personal supervision by the physician. The physician must be immediately available within the operating suite or within the immediate vicinity to assume primary care of the patient if needed.

When reporting medical direction of a CRNA employee, submit one claim with two separate lines for the anesthesiologist and CRNA services. Use the appropriate modifiers that identify the anesthesiologist and CRNA, as well as physical status or qualifying circumstances, if applicable.

Payment for the anesthesiologist who employs the CRNA will be 60% of the allowed amount and payment for the CRNA will be 40%. (Exception: Medicare Advantage products will be reimbursed at a 50/50 split.) Payment is calculated with the conversion factor multiplied by the total number of allowed units. ***Do not include the CRNA's name or provider number on the claim.***

Here is an example of correct reporting on a paper claim.

24. A. DATES OF SERVICE		B.	C.	D.		E.	F.	G.	H.	I.	J.	K.
FROM MM/YY	TO MM/YY	Place of service	Type of	SPENCER CODE (00000-99999)	MODIFIER	CHARGE CODE	CHARGES	DAYS OR UNITS	REPORT Family Plan	CMG	COB	RESERVED FOR LOCAL USE
07012005	07012005			00870	QK	1		251				001234567
07012005	07012005			00870	QX	1		251				
07012005	07012005			99100		1		1				

25. FEDERAL TAX ID NUMBER 123456789		SSN EIN <input type="checkbox"/> <input type="checkbox"/>	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For gov. plans, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO	28. TOTAL CHARGE \$	29. AMOUNT PAID \$	30. BALANCE DUE \$
31. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED: John Doe, MD			32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than home or office)		33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # Anesthesia Group Anywhere USA (800) 777-8888 PIN# 007854321 GRP#		

Medical Direction of a Non-Employed CRNA

When reporting medical direction of a non-employed CRNA, submit one line item and use the appropriate modifiers, as well as physical status, if applicable.

Services will be reimbursed at 100% of the allowed amount when personally performed by the physician or CRNA without medical direction by an anesthesiologist.

Refer to Medical Policy A-5.

Anesthesia Administered By the Operating Surgeon

IMPORTANT – Please see changes effective April 17, 2010 below:

Modifier 47 is appropriate to use when general or regional anesthesia has been administered by the operating surgeon.

When moderate (conscious) sedation has been administered by the operating surgeon, codes 99143-99150, as appropriate, should be reported. Anesthesia administered for covered services is eligible for reimbursement when ordered by the attending professional provider and rendered by a professional provider other than the operating surgeon, assistant surgeon, or attending professional provider. When anesthesia is reported by the operating surgeon, assistant surgeon, or attending professional provider, it is not covered.

Report the AA modifier and the actual number of minutes when billing moderate (conscious) sedation codes 99143, 99144, 99148, and 99149. Report AA modifier and actual number of minutes when billing 99145 and 99150 until December 31, 2008.

Effective January 1, 2009, when billing the add-on moderate (conscious) sedation codes, report the actual units on the claim. One unit equals each additional 15 minutes. Report in Box 24G on the CMS 1500. This applies to the following codes:

99145 Moderate sedation services (other than those described by codes 00100-01999) provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes intra-service time (List separately in addition to code for primary service)

99150 Moderate sedation services (other than those described by codes 00100-01999), provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intra-service time (List separately in addition to code for primary procedure)

Effective April 17, 2010, Mountain State Blue Cross Blue Shield is making changes to the anesthesia reporting requirements for moderate (conscious) sedation services on electronic and paper claim forms. As in the past, the administration of moderate sedation, also known as conscious sedation, for specified procedures, by the same provider is to be reported using procedure codes 99143-99145. And moderate sedation performed by **other than the** operating surgeon, assistant surgeon or attending professional is to be reported using procedure codes 99148-99150.

Providers should note the following two changes when reporting the administration of moderate sedation, effective April 17, 2010:

Whether using procedure codes 99143-99145 or 99148-99150, providers must report units, not minutes, for these codes.

Certification modifiers are no longer required.

Refer to Medical Policies A-2 and A-17.

Anesthesia Administered For A Noncovered Surgical Procedure

When a claim is received for anesthesia services which are provided in conjunction with a noncovered surgical procedure (i.e. cosmetic, not medically necessary), the physician's charge for the anesthesia service is not covered. Anesthesia services are reimbursable only if performed in conjunction with a covered surgical procedure.

Refer to Medical Policy A-1.

The Medical Policies referenced in this bulletin are Mountain State BlueCross BlueShield policy numbers. When treating Medicare Advantage members, please refer to the Medicare Advantage or Medicare Advantage Gap Fill policies.

It is important to submit your claims as outlined in this notice to avoid unnecessary rejection or delay of processing.

If you have questions regarding this notice please contact the Provider Relations Department of Mountain State Blue Cross Blue Shield at 1-800-798-7768 or your External Provider Relations Representative.