Anesthesia Payment Policy

Policy

Blue Cross Blue Shield of Massachusetts (Blue Cross*) reimburses contracted providers for covered, medically necessary anesthesia and related services. Providers requesting reimbursement for anesthesia services must be credentialed and contracted by Blue Cross.

Anesthesia is the loss of sensation as a result of medication or gases.

General benefit information

Covered services and payment are based on the member’s benefit plan and provider Agreement. Providers and their office staff may use our online tools to verify effective dates and member copayments before providing services. Visit our eTools page for information on member eligibility and benefits. Member liability may include, but is not limited to: copayments, deductibles, and co-insurance. Members’ costs depend on member benefits.

Certain services require prior authorization or referral.

Payment information

Blue Cross reimburses health care providers based on your contracted rates and member benefits.

Claims are subject to payment edits, which Blue Cross updates regularly.

Blue Cross reimburses:

- General anesthesia.
- Regional block anesthesia.
- Monitored anesthesia care (MAC) in lieu of general anesthesia.
- Non-anesthesia reimbursable services (CPT or HCPCS) based on the applicable fee schedule rate. Time units are not applicable.
- Payment is calculated on anesthesia base units plus anesthesia time units as reported by the provider, multiplied by the Blue Cross anesthesia conversion factor.
  - **Anesthesia base units**
    - Blue Cross uses the ASA Relative Value Guide by the American Society of Anesthesiologists (ASA) to determine anesthesia base unit values.
  - **Anesthesia time units**
    - Anesthesia time starts when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room or an equivalent area.
    - Time ends when the anesthesia practitioner is no longer furnishing anesthesia services to the patient, that is, when the patient is safely placed under postoperative care.
  - The reimbursement rate for anesthesia includes, but is not limited to:
    - Pre-anesthesia evaluation and post-operative visits.
    - Anesthesia care during the procedure including:
      - Administration of the anesthetic, fluids and/or bloods, and necessary drugs and materials provided by the anesthesiologist.
      - Usual monitoring (examples: ECG, temperature, blood pressure, oximetry, capnography, mass spectrometry) as defined by ASA and current procedural terminology (CPT) guidelines.
  - The most intensive ASA code per anesthesia service.
  - The insertion of a Swan Ganz line at 50% of the allowable fee schedule.
  - General anesthesia that is personally performed by the anesthesiologist, or under medical direction at a rate not to exceed 100% of the anesthesia service allowable.
Blue Cross does not reimburse:
- Qualifying circumstances.
- P1-P6 modifiers.
- Placement and insertion of a catheter to administer an epidural on the same day that epidural anesthesia was delivered during surgery. The base value of the anesthesia care includes catheter placement and insertion.
- Ventilation management on the same day as general anesthesia reported.
- Local anesthesia services.
- Post-operative pain consultations when performed on the same date of service as the surgical procedure.
- CRNAs under the medical direction of an anesthesiologist. The anesthesia services are reimbursed to the anesthesiologist.
- Medicare Advantage claims for ASA codes reported without a valid anesthesia modifier.
- Transesophageal echocardiography when billed with general anesthesia service codes.

General reimbursement information:
- Time is reported in one-minute increments.
  - Information about the Blue Cross anesthesia conversion factor can be found on the provider fee schedule.
- CRNAs (Medicare providers, please see Billing Information section below.)
  - Facilities:
    - Blue Cross reimburses anesthesia services that are reported with the applicable procedure code along with revenue code 963.
    - Blue Cross does not recognize the use of revenue code 964.
  - Independent CRNAs:
    - Report services using your own national provider identifier (NPI) number.
- CRNAs affiliated with a physician group:
  - Report and bill services under the physician’s NPI.
- Modifiers
  - Blue Cross accepts industry-standard modifiers to allow for accurate reporting of services and claim processing. See CPT and HCPCS Modifiers Payment Policy for a list of modifiers appropriate for reporting anesthesia services.
- Obstetrical and maternal care
  - Time caps apply to obstetrical anesthesia. See coding grid below.

Moderate sedation reimbursement information
- Attending physician
  - Moderate sedation is eligible for separate reimbursement.
  - Providers must use these codes when moderate sedation is provided by the same physician performing the procedure. All codes are subject to standard claim edits.
- Second physician
  - Moderate sedation provided in a facility setting, when rendered by a provider other than the provider performing the procedure, may be separately reimbursed when reported with modifier 59 or XP.
  - Moderate sedation provided in a non-facility setting will not be separately reimbursed. All codes are subject to standard claim edits.

Billing information

Specific billing guidelines:
- Bill anesthesia services using ASA anesthesia CPT codes. Anesthesia services reported with the corresponding surgical CPT code will reject.
- Report time in whole minutes or one-minute increments. Round up, if applicable. Do not report seconds, decimals, or fractions. Round up to the next one-minute increment. Do not submit or calculate the ASA base unit values.
- When anesthesia services are provided for multiple surgical procedures, only the anesthesia code for the most complex service (highest base value) is reported with the total time for all procedures performed.
- When reporting continuous epidural analgesia during labor, the time reported must reflect only the provider’s actual face-to-face time and/or the time in attendance when the provider is immediately available if needed.
- When surgical services have been discontinued after the anesthesiology provider has performed the preoperative exam:
  - Bill the appropriate evaluation and management code if the patient has not yet been prepared for the induction of anesthesia.
- Bill the applicable ASA code and time if the surgery is cancelled after the anesthesiologist has prepared the patient for induction.

- Bill anesthesia for electroconvulsive therapy (ECT) with ASA code 00104. One unit is reimbursed.

- Medicare Advantage:
  - All claims for services rendered to Medicare Advantage (Medicare HMO BlueSM and Medicare PPO BlueSM) members must be submitted to Blue Cross in accordance with the Centers for Medicare & Medicaid Services (CMS) guidelines. To meet CMS guidelines, please submit all claims on the 1500 claim form, or electronic claim equivalent, with valid anesthesia modifiers.
  - See grid below for modifier information. Claims submitted for services rendered to Medicare Advantage members must include modifiers or they will deny.

- Medicare member billing information:
  - When Blue Cross is the primary insurer, do not bill with the CRNA’s NPI for any product. CRNA services must be billed under the physician’s NPI.
  - When Medicare is the primary insurer and Blue Cross is secondary, follow Medicare guidelines for reporting CRNA services.

### Obstetrical time caps

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Time unit cap</th>
</tr>
</thead>
<tbody>
<tr>
<td>01960</td>
<td>Anesthesia for vaginal delivery only</td>
<td>4</td>
</tr>
<tr>
<td>01961</td>
<td>Anesthesia for cesarean delivery only</td>
<td>8</td>
</tr>
<tr>
<td>01967</td>
<td>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)</td>
<td>20</td>
</tr>
</tbody>
</table>

### Billing codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA</td>
<td>Anesthesia services performed personally by anesthesiologist</td>
<td>Commercial claims:</td>
</tr>
<tr>
<td>AD</td>
<td>Medical supervision by a physician: more than four concurrent anesthesia procedures</td>
<td>o Should report modifier.</td>
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<tr>
<td></td>
<td></td>
<td>Medicare Advantage claims:</td>
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<tr>
<td></td>
<td></td>
<td>o Must report modifier.</td>
</tr>
<tr>
<td>P1-P6</td>
<td>Physical status modifiers</td>
<td>No additional reimbursement</td>
</tr>
<tr>
<td>QK</td>
<td>Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals</td>
<td></td>
</tr>
<tr>
<td>QX</td>
<td>Qualified non-physician anesthetist with medical direction by a physician</td>
<td></td>
</tr>
<tr>
<td>QY</td>
<td>Medical direction of one qualified non-physician anesthetist by an anesthesiologist</td>
<td></td>
</tr>
<tr>
<td>QZ</td>
<td>CRNA service: without medical direction by a physician</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>Increased procedural services</td>
<td>May be considered for additional reimbursement after review of documentation. For example, for field avoidance or airway access limitations.</td>
</tr>
<tr>
<td>00100-01999</td>
<td>ASA anesthesia codes</td>
<td>Use to report general anesthesia service.</td>
</tr>
<tr>
<td>01967</td>
<td>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)</td>
<td>Includes any repeat subarachnoid needle placement or drug injection or any necessary replacement of the epidural catheter during labor.</td>
</tr>
<tr>
<td>01968</td>
<td>Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia (list separately in addition to code for primary procedure performed)</td>
<td>Must be reported with 01967.</td>
</tr>
<tr>
<td>36620</td>
<td>Arterial catheterization</td>
<td>Separately reimbursed.</td>
</tr>
<tr>
<td>36555-36556</td>
<td>Insertion of non-tunneled centrally inserted central venous catheter</td>
<td>Separately reimbursed.</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
<td>Comments</td>
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<tr>
<td>62320-62321</td>
<td>Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without/(with) imaging guidance</td>
<td>Bill with a count of one.</td>
</tr>
<tr>
<td>62322-62323</td>
<td>Injection(s), of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without/(with) imaging guidance</td>
<td></td>
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<tr>
<td>62324-62325</td>
<td>Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, cervical or thoracic; without/(with) imaging guidance</td>
<td></td>
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<tr>
<td>62326-62367</td>
<td>Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without/(with) imaging guidance</td>
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<tr>
<td>93312-93318</td>
<td>Transesophageal echocardiography</td>
<td>Not separately reimbursed when reported with general anesthesia services</td>
</tr>
<tr>
<td>93503</td>
<td>Insertion and placement of catheter (e.g. Swan-Ganz for monitoring purposes)</td>
<td>Reimbursed at 50% of fee schedule allowable when reported with an anesthesia code.</td>
</tr>
<tr>
<td>94002</td>
<td>Ventilation assist and management</td>
<td>Not reimbursed on same day as ASA code.</td>
</tr>
<tr>
<td>99100</td>
<td>Anesthesia for patient of extreme age, younger than 1 year and older than 70</td>
<td>No additional reimbursement.</td>
</tr>
<tr>
<td>99116</td>
<td>Anesthesia complicated by utilization of total body hypothermia</td>
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<tr>
<td>99135</td>
<td>Anesthesia complicated by utilization of controlled hypotension</td>
<td></td>
</tr>
<tr>
<td>99140</td>
<td>Anesthesia complicated by emergency conditions</td>
<td></td>
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<tr>
<td>99151</td>
<td>Moderate sedation services provided by the same physician or other qualified health care professional 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; initial 15 minutes of intra-service time, patient younger than 5 years of age.</td>
<td>Eligible for separate reimbursement Use HCPCS code G0500 to bill moderate sedation with gastroenterology procedure codes.</td>
</tr>
<tr>
<td>99152</td>
<td>Moderate sedation services provided by the same physician or other qualified health care professional 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; initial 15 minutes of intra-service time, patient age 5 years or older.</td>
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</tr>
<tr>
<td>99153</td>
<td>Moderate sedation services provided by the same physician or other qualified health care professional 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).</td>
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</tr>
<tr>
<td>99155</td>
<td>Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intra-service time, patient younger than 5 years of age.</td>
<td>Moderate sedation provided in a non-facility setting will not be separately reimbursed.</td>
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<tr>
<td>Code</td>
<td>Description</td>
<td>Comments</td>
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<tr>
<td>99156</td>
<td>Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intra-service time, patient age 5 years or older.</td>
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</tr>
<tr>
<td>99157</td>
<td>Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified 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 service).</td>
<td>Eligible for separate reimbursement. Additional time may be reported with CPT 99153.</td>
</tr>
<tr>
<td>G0500</td>
<td>Moderate sedation services provided by the same physician or other qualified health care professional performing a gastrointestinal endoscopic service (excluding biliary procedures) 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; initial 15 minutes of intra-service time.</td>
<td></td>
</tr>
</tbody>
</table>

**Billing and coding scenarios**

**Example 1:**
**Reporting time**
- An anesthesiologist begins to prepare the patient for the induction of anesthesia at 8 a.m.
- At 9:18 a.m. the patient is placed under post-operative supervision and the anesthesia provider is no longer in constant attendance.

Bill time as **78 minutes**.

**Example 2:**
**Reporting time**
- An anesthesiologist begins to prepare the patient for the induction of anesthesia at 8 a.m.
- At 9:18 and 45 seconds a.m. the patient is placed under post-operative supervision and the anesthesia provider is no longer in constant attendance.

Bill time as **79 minutes**.

Do not report decimals or fractions of a minute.

Instead, round up to the next full minute.

**Example 3:**
**Multiple anesthesia services**
- An anesthesiologist provides anesthesia while the surgeon performs an iridectomy (ASA code 00147) in the left eye with 49 minutes total anesthesia time.
- A soft tissue biopsy on the nose (ASA code 00164) is performed in the same operative session, taking an additional 15 minutes.

Bill only the single anesthesia code with the highest base value – 00147 – with **64 minutes**.

The time is the combined total for all procedures performed at the same session by same or different provider.

**Example 4:**
**Obstetrical anesthesia**
- An anesthesiologist provides 5.5 hours of labor and delivery time for neuraxial analgesia.

Bill 01967 with time as **330 minutes**.

Reimbursement will be capped at 300 minutes or 20 units.

When submitting claims, report all services with:
- Up-to-date industry-standard procedure and diagnosis codes, and
- Modifiers that affect payment in the first modifier field, followed by informational modifiers.

**Related policies**
- CPT and HCPCS Modifiers
- Evaluation and Management
- General Coding and Billing
- Obstetrical and Maternity Care

**Policy update history**

03/01/2011  Original documentation of policy
Payment policies are intended to help providers obtain Blue Cross Blue Shield of Massachusetts’ payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy development takes into consideration a variety of factors, including: the terms of the participating provider’s contract(s); scope of benefits included in a given member’s benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.