



POLICY INFORMATION			
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NOTICE

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Blue KC reserves the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to: <https://providers.bluekc.com/ContactUs/PaymentPolicies>.

PROVIDER/ENTITY IMPACTED					
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
PROFESSIONAL	FACILITY	DME	AMBULATORY SURGERY	LAB	OTHER

LINES OF BUSINESS IMPACTED						
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
COMMERCIAL	BLUE MEDICARE ADVANTAGE	ACA QHP¹	SMALL GROUP ACA	JAA²	FEP³	DENTAL

¹ ACA QHP: Affordable Care Act Qualified Health Plan for Individual/Family ² JAA: Joint Administrative Account ³ FEP: Federal Employee Program

Disclaimer

Blue KC has developed Provider Payment Policies to provide guidance on payment methodologies as they pertain to submitted claims. These policies are written following industry standard recommendations from sources such as:

- Current Procedural Terminology
- Centers for Medicare and Medicaid
- American Medical Association
- National Correct Coding Initiative
- Other professional organizations and societies

Coverage of any service is determined by date of service, a member's eligibility and benefit limits for the service or services rendered, all terms of the Provider Service Agreement, and other standards of coding rules and guidelines.

Final payment is subject to the application of claims adjudication and edits common to the industry.

For confirmation of which services may be eligible for coverage and description of when medical services are considered medically necessary, not medically necessary, or investigational, please contact:

- Blue KC Provider Hotline for Commercial lines of Business 816-395-3929
- Affordable Care Act Provider Hotline 866-859-3822
- Blue Medicare Advantage Provider Hotline 866-508-7140

In the event of a conflict between any policies, the Member's coverage document will govern.



Description/Application

Anesthesia is a medical state of pain relief achieved through the use of anesthetics, drugs that block pain signals to the brain. It allows for medical and surgical procedures to be performed safely and painlessly. There are different types of anesthesia, including general, regional, and local anesthesia, each with specific applications and mechanisms.

Policy

Anesthesia and Surgery/Procedure by the Same Physician

- If the same physician performs anesthesia and surgery, the anesthesia is considered inclusive with the surgery. No separate or additional benefit is available for the anesthesia since the patient is not managed separately from an anesthesia standpoint.
- Regardless of the mode of anesthesia, preparation and monitoring services are not separately reportable with anesthesia service codes when performed in association with the anesthesia service. However, if the provider of the anesthesia service performs 1 or more of these services prior to and unrelated to the anticipated anesthesia service or after the patient is released from the anesthesia practitioner's postoperative care, the service may be separately reportable with modifiers 59 or -X{E,U}
- Anesthesia provided by a dentist is to be billed with the appropriate D-code

Multiple Anesthesia Services

When a patient undergoes multiple surgical procedures on the same day, anesthesia is billed based on the procedure with the highest base unit value. The total anesthesia time is the combined time for all procedures performed that day, not a separate charge for each procedure.

Any additional anesthesia services billed for the same patient on the same day will be denied.

Field Avoidance

Field avoidance is when an anesthesiologist does not have direct access to the patient's airway during surgery. Charges for field avoidance will not be reimbursed.

General anesthesia

General anesthesia is a medically induced coma with loss of protective reflexes, resulting from the administration of one or more general anesthetic agents.

- For a vaginal delivery with general anesthesia (no epidural), use code 01960 (5 ASA units). This would allow the ASA value of 5 units plus the actual time units for the surgery.
- For a Cesarean delivery with general anesthesia (no epidural), use code 01961 (7 ASA units). This would allow the ASA value of 7 units plus the actual time units for the surgery.
- For a Cesarean hysterectomy following neuraxial labor analgesia/anesthesia, use code 01969 in addition to code 01967. This would allow the ASA value of 5 units for 01969 and 5 units for 01967 plus the actual time units



for the surgery

- Continuous Epidural Analgesia for Labor and Delivery (01960, 01961, 01967, 01968, 01969)
- For vaginal delivery, code 01967. The code will be priced per the R&C schedule and automatically priced one unit.
- For a vaginal delivery that turns into a Cesarean, the code representing the most complex procedure is reported. The time reported is the combined total for all procedures.
- For a scheduled/planned Cesarean delivery using an epidural, use code 01961 (7 ASA units). This would allow the ASA value of 7 units plus the actual time units for the surgery

Intravenous Sedation or Moderate Sedation

- A physician or trained health care professional administers medication that allows a decreased level of consciousness but does not put the patient completely asleep, inducing a state called moderate (conscious) sedation. This allows the patient to breathe without assistance and respond to commands.
- Intravenous anesthesia or moderate sedation administered by a qualified medical person working under the direction of the physician for procedures appearing in Appendix G of the AMA's Current Procedure Terminology (CPT) book is considered a component of the procedure itself. No separate or additional reimbursement will be allowed.
- Moderate sedation by a second physician requires individual review and would be considered appropriate when ALL the following are met:
 - Medically unstable patient or a patient for whom the sedation is necessary to allow safe completion of the procedure, AND
 - Service provided in a facility, AND
 - Service provided by a physician other than the health care professional performing the diagnostic or therapeutic service. Anesthesiologists should not use these codes

A separate benefit is not provided for supplies and medications related to intravenous sedation, as they are considered included in the reimbursement made for the procedure, or the facility fee paid to the provider.

Intubation and Ventilation Services (31500, 94002, 94003, 94004)

- Endotracheal intubation performed by an anesthesiologist or CRNA, in the course of surgery, is included in the time units reported for anesthesia.
- Endotracheal intubation performed independent of surgery, by a physician or CRNA may be allowed as surgical procedure itself, not as an anesthesia service.
- Initiation of mechanical ventilation, in the course of surgery, is included in the time units reported for



anesthesia.

- Initiation of mechanical ventilation after endotracheal intubation (code 31500) performed independent of a surgery (e.g., in the intensive care setting) may be reimbursed separately. Ventilation management services will be reimbursed only one time per day.

Local Anesthesia

- Local anesthesia includes the direct infiltration of the incision, wound, or lesion, a digital block, or topical anesthesia.
- Local anesthesia is an integral part of the surgical procedure, and no separate or additional reimbursement will be allowed.

Monitored Anesthesia Care (MAC)

Like general anesthesia, monitored anesthesia care uses sedatives and other agents, but the dosage is low enough that patients remain responsive and breathe without assistance.

MAC is often used to supplement local and regional anesthesia, particularly during simple procedures and minor surgery. During MAC, the patient is sedated and amnesic but always remains responsive when stimulated to do so. The patient is in a light sleep and may or may not wake up from time to time during the procedure even if he does not remember doing so.

The patient breathes on his/her own and ventilation is not assisted as in general anesthesia. The patient is usually awake at the end of the procedure and can readily be discharged from the recovery room.

The anesthesiologist or CRNA administering MAC must be continuously present to monitor the patient and provide anesthesia care. The MAC service must be reasonable and medically necessary under the given circumstances.

- Monitored anesthesia care includes all aspects of anesthesia care a pre-procedure visit, intra-procedure care and post-procedure anesthesia management. The anesthesiologist provides or medically directs a number of specific services, including but not limited to:
 - Diagnosis and treatment of clinical problems that occur during the procedure
 - Support of vital functions
 - Administration of sedatives, analgesics, hypnotics, anesthetic agents, or other medications as necessary for patient safety
 - Psychological support and physical comfort
 - Provision of other medical services as needed to complete the procedure safely

The provider of MAC must be prepared and qualified to convert to general anesthesia when necessary. If the patient loses consciousness and the ability to respond purposefully, the anesthesia care is a general anesthetic, irrespective of whether airway instrumentation is required.

MAC is subject to the same level of reimbursement as general or regional anesthesia and is reported using the appropriate anesthesia code and modifier (QS).



Patient Controlled Analgesia (PCA) (01996, 36557, 36558, 36560, 36561, 36563, 36565, 36566, 36570, 36571, 36575, 36576, 36578, 36581, 36582, 36583, 36584, 36585, 36589, 36590, 62350, 62351, 62360, 62361, 62362)

The most common routes for Patient Controlled Analgesia (PCA) are:

- Intravenous – (into a vein) the pump and tubing are connected to a needle or soft catheter that has been placed in a vein
- Subcutaneous – (under the skin) the pump and tubing are connected to a small thin needle that is placed under the skin
- Epidural – into the area surrounding the Dural membrane, which contains cerebral spinal fluid and spinal nerves or
- Intrathecal – (through the Dural membrane and into the spinal fluid) the pump and tubing are connected to a flexible catheter that causes drug to come in contact with spinal nerves.

Pain controlled analgesia refers to a method of giving pain medication that can be controlled by the patient, within the physician’s prescribed parameters. These parameters are programmed into a computerized or mechanical pump and may deliver either boluses (a “shot”) of the pain medication when the patient pushes a button or a basal rate (continuous dose) or both.

With the lower doses generally needed to obtain pain relief, side effects such as nausea, sedation and respiratory depression can be minimized. This type of pain control is used extensively for postoperative pain. It is also used for management of pain due to cancer and for chronic intractable pain of non-cancerous origin.

PCA may be utilized in the home under the care of a licensed home health agency or in the hospital setting.

Intravenous or subcutaneous PCA:

When PCA is initiated by an anesthesiologist before the patient leaves the operating room or in the recovery room immediately after surgery, the set-up time may be incorporated into the total number of anesthesia time units reported.

Any intravenous or subcutaneous PCA follow-up services performed after the surgical anesthesia care has ended are considered routine postoperative pain management, regardless of who performs them. When performed by the physician who administered anesthesia, or by a member of his group or association, postoperative pain management is considered part of the global anesthesia allowance. As such, if billed separately, the pain management is not covered.

Intravenous or subcutaneous PCA ordered by the surgeon, or other attending physician and administered for pain management is considered an integral part of a physician’s medical care. It is not eligible for benefit as a separate and distinct service.

If an anesthesia consultation is required for pain management, whether or not it results in initiation of PCA (intravenous or subcutaneous), the anesthesiologist should submit a claim under the appropriate CPT Evaluation and Management code.

CPT code 01999 may not be used to bill PCA Management.



Epidural (or subarachnoid, or intrathecal) PCA

For the insertion of an epidural catheter to be separately reimbursable, it must be performed outside of the general anesthesia time. If the epidural catheter is placed in the operating room when the anesthesiologist is tracking time for the general anesthetic procedure, it would not be separately reimbursable.

If, however, the epidural placement is done pre-op or post-op for pain management, the diagnosis should reflect it was done for pain management, and it would be appropriate for the provider to bill with the -59 modifier. Providers will not be reimbursed in addition to continuous epidural analgesia for labor and delivery 01960, 01961, 01967, 01968.

Daily Management of epidural drug administration (code 01996) is also eligible for separate payment after the day on which the catheter is inserted. Daily Management reported on the same day as the catheter insertion is considered inclusive with the insertion.

Daily pain management services beyond three days may be subject to medical review for medical necessity.

Payment can also be made for the insertion of an epidural catheter for the treatment of a nonsurgical condition. Daily Management of epidural drug administration (code 01996) is also eligible for separate payment after the day on which the catheter is inserted. Daily Management reported on the same day as the catheter insertion is considered inclusive with the insertion.

Pre-Anesthetic Evaluation

The pre-anesthetic evaluation should include the following components at a minimum:

- An evaluation of chief complaint.
- Past medical history.
- Review of individual sensitivities to drugs and biologicals.
- Assessment of the patient as a whole.

The pre-anesthesia evaluation is considered an integral part of the anesthesia service and separate benefits are not provided, with the following exception:

- Benefit may be provided at the E & M (evaluation and management) level of care rendered (under CPT consultation codes) by an anesthesiologist only if the anesthesia is not subsequently administered during the same hospital stay.

Regional Nerve Blocks (64400, 64402, 64405, 64408, 64410, 64413, 64415, 64416, 64417, 64418, 64420, 64421, 64425, 64430, 64435, 64445, 64446, 64447, 64448, 64449, 64450)

In a regional (or field) block, medication is injected around a large nerve or nerves. These nerves give a sensation to the site of the procedure. Regional blocks are usually done in an operating room. Unlike local numbing, the medication is injected far away from the procedure site. Although regional blocks cause a larger area of the body to be numb than local anesthesia, the medication is the same.

- Nerve blocks may be used for:
 - Surgery – to provide anesthesia for orthopedic, obstetric, and vascular surgical procedures.
 - Therapeutic – to treat chronic pain in certain areas of the body. The effect is usually temporary, although the length of effect may vary, from hours to months.



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- Diagnostic – to diagnose which neural pathway is causing chronic pain.
 - Blocks done by an anesthesiologist for anesthetic purposes:
 - Anesthetic blocks performed by an anesthesiologist or CRNA for an operative procedure should be processed as general anesthesia, based on the anesthesia value for the surgical procedure and duration of the anesthesia period.
 - Blocks done for diagnostic or therapeutic purposes:
 - If the block is done for post-op analgesia (pain management) and is not the primary anesthetic for the surgical procedure, then it would be appropriate for the provider to bill with the -59 modifier and get reimbursed separately. Whether the block procedure occurs preoperatively, postoperatively, or during the procedure is immaterial.
 - When there is no separate operative procedure performed and the anesthesiologist performs a block as treatment for intractable pain, the claim should be processed under the appropriate CPT code and reimbursed as surgery.

Stand-by Anesthesia (99360)

- Standby service describes a physician who is available in the immediate area to perform needed service. There is no direct patient contact included in the standby service.
- Stand-by anesthesia services are not eligible for coverage even when required by the facility in which the patient is to have surgery. When there is no direct patient care by the anesthesiologist or CRNA (e.g., anesthesia availability for PTCA, delivery, etc.) no benefit is provided

Description of Procedure or Service

- When multiple surgical procedures are performed during a single anesthetic administration, the anesthesia code representing the most complex procedure is reported. The time reported is the combined total for all procedures
- The administration of anesthesia services is appropriate by an anesthesiologist or Certified Nurse Anesthetist (CRNA) under the responsible supervision of an anesthesiologist. These services include the usual preoperative and postoperative visits, the anesthesia care during the procedure, the administration of fluids and/or blood and the usual monitoring services (e.g., ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry).
- The period of time on which anesthesia time units are based begins when the anesthesiologist or CRNA is first in attendance with the patient for the purpose of induction of anesthesia, and ends when the patient leaves the operating room, delivery room, or treatment room (in the case of Monitored Anesthesia Care or MAC). Time spent in the recovery room is included in the anesthesia base units and no additional units of time are provided.

The following components are considered an integral part of the anesthesia service and additional benefits are not provided:

- Pre-anesthesia evaluation.
- Postoperative visits.
- Anesthetic or analgesic administration.



- All necessary monitoring

National Correct Coding Initiative

The National Correct Coding Initiative (NCCI) was developed to promote national correct coding methodologies and to control improper coding leading to inappropriate payment of services that should not be reported together.

- **Standard Preparation/Monitoring Services for Anesthesia**

With few exceptions, anesthesia HCPCS/CPT codes do not specify the mode of anesthesia for a particular procedure. Regardless of the mode of anesthesia, preparation and monitoring services are not separately reportable with anesthesia service HCPCS/CPT codes when performed in association with the anesthesia service. However, if the provider/supplier of the anesthesia service performs 1 or more of these services prior to and unrelated to the anticipated anesthesia service or after the patient is released from the anesthesia practitioner’s postoperative care, the service may be separately reportable with modifiers 59 or XE or XU.

- **Anesthesia Service Included in the Surgical Procedure**

Under CMS Anesthesia Rules, with limited exceptions, Medicare does not allow separate payment for anesthesia services performed by the physician who also furnishes the medical or surgical service. In this case, payment for the anesthesia service is included in the payment for the medical or surgical procedure. Likewise, under OPPS, payment for the anesthesia service is generally included in the payment for the medical or surgical procedure. For example, separate payment is not allowed for the physician’s performance of local, regional, or most other anesthesia including nerve blocks if the physician also performs the medical or surgical procedure. Medicare generally allows separate reporting for moderate conscious sedation services (CPT codes 99151-99153) when provided by the same physician performing a medical or surgical procedure except when the anesthesia service is bundled into the procedure, e.g., radiation treatment management.

Anesthesia Physical Status Modifiers

Physical status modifiers are used to indicate physical status during the anesthesia procedure. These modifiers are informational only and do not affect payment and should be placed after pricing modifiers.

Coding

Anesthesia codes 00100 - 01999

References and Resources

- Centers for Medicare and Medicaid Services
- American Medical Association CPT Manual
- Blue KC Provider Reference Guide
- National Correct Coding Initiative

Related Documents

N/A



Revision History		
Version	Date	Summary of Revisions
001	07/01/2019	Initial version
002	07/01/2020	Annual review, there were no changes.
003	07/01/2021	Annual review, there were no changes.
004	11/30/2021	Correction to formatting
005	07/01/2022	Clarified statement "Physical status modifiers are informational only and do not affect payment"
006	07/01/2023	Annual review, there were no changes
007	07/01/2024	Annual review, there were no changes
008	07/01/2025	Annual review- information added on multiple anesthesia procedures for same patient, same date of service., and NCCI guidelines on Standard Preparation/Monitoring Services for Anesthesia, and Anesthesia Service Included in the Surgical Procedure