BlueCross BlueShield of South Carolina and
BlueChoice® HealthPlan of South Carolina

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Anesthesia Guidelines

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Your Partners in Outstanding Quality, Satisfaction and Service

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BlueCross BlueShield of South Carolina and BlueChoice HealthPlan require anesthesiologists and certified registered nurse anesthetists (CRNAs) to file claims using CPT anesthesia codes. We cover general anesthesia services when the operating physician requests them and a nurse anesthetist or physician, other than the operating physician, performs them for covered surgical services. BlueCross and BlueChoice® cover anesthetic or sedation procedures the operating physician performs as a part of the surgical or diagnostic procedure. We consider local anesthesia to be an integral part of the surgical procedure and provide no additional benefits. BlueCross and BlueChoice recognizes these modifiers:

Anesthesiologist Modifiers

- **AA** – Anesthesia services performed personally by an anesthesiologist (includes reimbursement of an employed CRNA)
- **AD** – Medical supervision by a physician. More than four concurrent anesthesia procedures.
- **QK** – Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals
- **QY** – Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist

CRNA Modifiers

- **QX** – CRNA service with medical direction by a physician
- **QZ** – CRNA service without medical direction by a physician

Monitored Anesthesia Care Modifiers

BlueCross and BlueChoice may reimburse for modifiers QS, G8 and G9 if a physician personally performs the procedure (modifier AA) and if the procedure meets medical necessity criteria. BlueCross and BlueChoice will not reimburse modifiers QK, QX, QY and QZ for supervision of monitored anesthesia care (MAC). BlueCross and BlueChoice will not reimburse CRNAs for MAC.

- **QS** – Monitored anesthesia care service (must appear in the second modifier field)
- **G8** – Monitored anesthesia care (MAC) for a deep complex, complicated or markedly invasive surgical procedure (must appear in the second modifier field)
- **G9** – Monitored anesthesia care for a patient who has a history of severe cardiopulmonary condition (must appear in the second modifier field

Anesthesia Risk Factors

Anesthesiologists or nurse anesthetists can file three modifiers indicating they have added time limits when the physical status of the patient presented a serious health risk. They must place these modifiers in the second modifier field of the claim form.

BlueCross and BlueChoice will only pay risk factors if the physician (modifier AA on the primary anesthesia code) administers the anesthesia personally. There will be no separate reimbursement for risk factors for CRNAs or anesthesiologist supervision of CRNAs, even if they report it separately.

Risk Modifiers

P-3	Add one time unit when a patient has a severe systemic disease, such as uncontrolled diabetes or hypertension requiring medication.
P-4	Add two time units when a patient has a severe systemic disease that is a constant threat to life, such as severe respiratory or cardiac disease.
P-5	Add three time units when the patient is not expected to survive for 24 hours with or without the operation, such as multiple severe trauma or severe head injury.

Maternity Epidural Anesthesia

BlueCross and BlueChoice reimburse epidural anesthesia for maternity as a global allowance with no consideration of time units. Generally, the practitioner who inserts the epidural needle will file for the total service using modifier AA. If, however, the physician and the CRNA have arranged to both bill for the epidural, the physician should bill either modifier QK or QY and the CRNA should bill with modifier QX.

To report obstetrical epidural administration, physicians should file code 01967 for normal delivery. Physicians should report both codes 01967 and 01968 when performing a cesarean section. Physicians should not report this code for "standing- by" if the patient elects natural childbirth and no epidural is performed.

Stand-by Anesthesia

BlueCross and BlueChoice provide benefits if the anesthesiologist offers the personal patient care normally provided when administering anesthesia (e.g., examines patient, connects monitoring lines, personally monitors patient during operative procedure), but does not actually administer the anesthesia unless required. BlueCross may reimburse the anesthesiologist for both the procedure and time. File claims for stand-by anesthesia using the appropriate anesthesia code, anesthesia modifier and time units.

Qualifying Circumstances

Physicians provide many anesthesia services under particularly difficult circumstances, depending on factors such as an extraordinary condition of patient, notable operative conditions and unusual risk factors. These circumstances significantly impact the character of the anesthesia service the physician provides.

BlueCross and BlueChoice may only reimburse qualifying codes if the physician administers the anesthesia personally. There will be no separate reimbursement for risk factors for CRNAs or anesthesiologist supervision of CRNAs, even if providers report these separately.

If a CRNA inserts the needle under the direct supervision of an anesthesiologist, the anesthesiologist may bill a QK modifier.

Conscious Sedation

Physicians use sedation with or without analgesia to achieve a medically controlled state of depressed consciousness while maintaining the patient’s airway, protective reflexes and ability to respond to stimulation or verbal commands. Benefits for this service are included in the benefits BlueCross and BlueChoice provide for medical care consultations or surgical care, including the pre- and postoperative care. BlueCross may provide reimbursement for this service if the age of the patient is less than 13 years.

Nerve Blocks

BlueCross and BlueChoice include administration of a nerve block in the allowance for total anesthesia time and it is not eligible for separate reimbursement.

When the nerve block is a separate procedure and is for the treatment of a non- surgical condition or for non-postoperative pain management, providers should bill it using the appropriate surgical procedure.

Anesthesia Units

Base Units

BlueCross and BlueChoice use the Medicare base units as a basis for procedures.

Time Units

Providers should report anesthesia time units in minutes. BlueCross and BlueChoice calculate the number of units for claims adjudication based on 15-minute increments, rounded to the nearest tenth (1/10). For example, we would calculate 49 minutes as follows:

49 minutes/15 increment = 3.266 units
3.266 would round to 3.3 time units

We do not provide anesthesia benefits for:

- The administration of anesthesia for non-covered services, such as cosmetic surgery.

We do not provide separate benefits for the following if in conjunction with other surgical or medical services:

- Pre-operative anesthesia consultation
- Transesophageal cardiography
- Emergency intubation
- The administration of anesthesia by the attending surgeon or surgical assistant, except as outlined above
- Local anesthesia

Anesthesia FAQs

Will BlueCross and BlueChoice cover anesthesia when a physician provides it with a non- covered service?
No. When a physician provides anesthesia services with a non-covered service, BlueCross and BlueChoice will not cover the physician's charge for the anesthesia, except for general anesthesia for dental surgical procedures that are covered under a separate dental contract.

When does anesthesia time begin and end?
Anesthesia time begins when the anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room or in an equivalent area and ends when the patient may be safely placed under post-operative supervision.

Will BlueCross and BlueChoice cover anesthesia when the attending or assisting physician administers it?
BlueCross and BlueChoice will not provide benefits when the attending or assisting physician administers anesthesia, except for regional anesthesia administered during delivery.

Are there special processing procedures for catheters?
If a physician bills a Swan-Ganz catheter, central venous pressure (CVP) and arterial lines in conjunction with the administration of anesthesia, the reimbursement will be 50 percent of the allowance for the catheterization and/or insertion of arterial lines and 100 percent of the allowance for the administration of anesthesia. However, if the physician bills them without administration of anesthesia, the allowance for the Swan-Ganz catheter is 100 percent and the allowance for the CVP and arterial lines is 50 percent.