Aetna Anesthesia Updates

The following applies to all Anesthesia articles in this update:
The policies described below may not apply to physicians who participate in Aetna through an IPA, PMG or PHO. Please contact your IPA/PMG/PHO for further information.
The policies described below are in effect as of July 2002. All policies are subject to revision.

In 2001, Aetna completed a review of its policies related to payment for anesthesia services. The following policies apply to all benefits plans. Please contact your Aetna representative with any questions.

The following general policies continue to apply:

- When anesthesia services are provided with a non-covered service, the physician's charge for the anesthesia is also not covered.
- Payment for eligible medical and surgical services performed in conjunction with eligible anesthesia services are subject to all claims processing guidelines, including multiple surgery processing logic. Modifier 51 exempt logic and add-on logic are considered when determining the services subject to multiple surgery processing

Payment for Anesthesia Services

Anesthesia Base Units and Time Factors

Payment for anesthesia services is based on anesthesia base units (which reflect procedure complexity) with any covered modifying units and the actual anesthesia time units. The time units and modifying units vary with each case, but the base units are constant for a given procedure. According to the American Society of Anesthesiologists (ASA), the units paid are determined by adding the anesthesia base units plus covered modifying units plus time units.

Base unit values have been assigned to most surgical procedures by the ASA. They reflect the difficulty of the anesthesia services, including the usual pre-operative and post-operative care. Anesthesia time is defined as the continuous presence of the anesthesiologist or anesthetist. It starts when the patient is first prepared for anesthesia care and ends when the patient is placed under post-operative supervision. Time units are determined on the basis of 1 time unit for each 15 minutes of anesthesia. Actual anesthesia time should be reported in minutes.

When actual anesthesia time is not in equal increments of 15 minutes, time units are computed by dividing the reported anesthesia time by 15 minutes, and rounding to one decimal place (nearest 10th). If system constraints prohibit rounding using decimals, Aetna will round up to allow a full-time unit when the actual anesthesia time is or exceeds 8 minutes of a single 15-minute time unit.

Physical Status and Qualifying Circumstances

Many anesthesia services are provided under difficult circumstances and/or when the patient's physical status is impaired. This adds to the complexity of the anesthesia service provided and may be reported by utilizing physical status modifiers and/or qualifying circumstance codes. When these modifiers/codes are reported, additional ASA units may be allowed and combined with the base unit value for the anesthesia service performed.

Aetna will reimburse additional anesthesia units for the following physical status modifiers:

- P3 – A patient with severe systemic disease
- P4 – A patient with severe systemic disease that is a constant threat to life
- P5 – A moribund patient who is not expected to survive without the operation

Aetna will also allow separate payment for the following covered qualifying circumstances:

- 99116 – Anesthesia complicated by utilization of total body hypothermia
- 99135 – Anesthesia complicated by utilization of controlled hypotension

NOTE: Additional units will not be recognized for the following qualifying circumstances and physical status modifiers:

- 99100 – Anesthesia for a patient of extreme age (under 1 year of age and over 70 years old)
- 99140 – Anesthesia complicated by emergency condition
- P1 – A normal, healthy patient
- P2 – A patient with mild systemic disease
- P6 – A declared brain-dead patient whose organs are being removed for donor purposes

Medical and Surgical Services Provided by Anesthesiologists

In addition to providing anesthesia care, anesthesiologists may perform medically necessary surgical and medical services. These include:
Swan-Ganz catheter insertion (CPT 93503)
Central Venous Pressure (CVP) line insertion (CPT 36488 – 36491)
Intra-arterial lines insertion (CPT 36620-36625)
Transesophageal echocardiography (CPT 93312-93318)
Aetna will pay under the physician fee schedule for the services listed above when furnished by the anesthesiologist, subject to all current claims processing guidelines.

Emergency intubation (CPT 31500) services may be provided by an anesthesiologist. However, these services are considered to be an integral part of the anesthesia care, whether provided in an emergency situation or not, and are included in the base anesthesia services. Emergency intubation not rendered in conjunction with anesthesia services is reimbursable.

Payment Guidelines for Administering Nerve Blocks (CPT Codes 64400—64530)

Time spent by an anesthesiologist administering a nerve block (i.e., injecting an anesthetic agent into or around a given nerve) is included in the total anesthesia time. Therefore it is not eligible for separate payment. Additional reimbursement is warranted when identified as a distinct procedure by use of modifier –59, for example, if a nerve block is performed primarily for postoperative pain management. Please note that appropriate use of this modifier may be subject to review and all current claim processing guidelines. When the nerve block is billed alone and is for the treatment of a ***non-surgical*** condition, it should be billed under the appropriate injection/block code. Aetna allows separate payment for covered non-surgical nerve block procedures subject to all current claims processing guidelines.

Payment Guidelines for Administering Conscious Sedation (CPT 99141 and 99142)

Aetna does not provide separate payment for Conscious Sedation (CPT 99141 or 99142). These codes are not billable by anesthesiologists. Further, conscious sedation administered in conjunction with diagnostic, therapeutic or minor procedures is considered integral to the provision of the primary service.

Payment Guidelines for Patient Controlled Analgesia

Patient controlled analgesia (PCA) pain management involves the self-administration of intravenous drugs through an infusion device.
When PCA is initiated, Aetna will pay for the initial catheter insertion, if not performed as part of a surgical anesthesia. Time units and anesthesia base units are not applicable in this instance. Aetna will provide payment for postoperative PCA evaluation and management services when billed with an appropriate Evaluation & Management code, with appropriate supporting documentation.

Payment Guidelines for Epidural Anesthesia

Epidural anesthesia involves the administration of a narcotic drug either through an epidural catheter or by a single dose injection. When eligible, Aetna will provide payment for the insertion of the epidural catheter and injection when reported with CPT codes 62310 to 62319.

Except for obstetrical care (see below), if an epidural is the mode of anesthesia for a surgical procedure, payment will be based on the surgical procedure's base and time units. Separate payment will not be provided for the epidural insertion.
When providing epidural-related services for obstetrical care, the actual anesthesia time should be reported. When eligible, Aetna will pay:

- One (1) time unit per hour of labor for obstetrical patients receiving a continuous infusion epidural.
- One (1) time unit for each 15 minutes of actual delivery time. In the absence of a definitive time, Aetna will use a delivery time of 1 hour.
- Continuous epidural anesthesia on labor and delivery services should be reported using either ASA code 01967 (vaginal delivery) or codes 01967 and 01968 (cesarean delivery).
- If the mode of anesthesia during labor is converted to general anesthesia for the delivery, report ASA code 01960 (vaginal delivery) or code 01961 (cesarean delivery) plus the labor and delivery time. Aetna will provide payment for these base/time units in addition to units relating to anesthesia service (labor epidural).

Payment Guidelines for Postoperative and Therapeutic Pain Management

Various methods of postoperative and therapeutic pain management exist, including the use of epidural analgesia. Epidural analgesia involves the administration of a narcotic drug or local anesthetic either through an epidural catheter or by a single dose injection. Aetna will provide payment for the eligible insertion of the epidural when performed for therapeutic, non-surgical, pain management.

Epidural and nerve blocks performed for postoperative pain management, provided that they are not the mode of anesthesia, are eligible for reimbursement when identified by modifier 59 as a distinct procedure.

Daily management of the therapeutic epidural administration (ASA code 01996) will be considered eligible and separately payable to the anesthesiologist if performed **after** the day on which the catheter was inserted. Payment will not be allowed for both the catheter insertion and the daily management of the drug when done on the same day.
Daily pain management services beyond three (3) days will be subject to clinical review to determine if the service(s) meet Coverage Policy Bulletin guidelines.

Mobile Anesthesia Charges

Aetna does not provide separate payment for the use of office equipment needed for administration of anesthesia regardless of whether it is onsite or must be transported to the physician's office.
For office-based surgical procedures, charges for the transportation and set up of equipment for the administration of anesthesia are not eligible for payment. Transportation and setup of equipment is considered incidental to and included in the global surgical package for the procedure performed and is not separately payable.

Certified Registered Nurse Anesthetist (CRNA)

A Certified Registered Nurse Anesthetist (CRNA) is a registered nurse who is licensed by the state in which they practice. Aetna will recognize a CRNA as an eligible practitioner under a signed provider contract or state mandate. Payment will be provided for covered CRNA services when reported with one of the following HCPCS modifiers:

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

Payment for the administration of anesthesia under these circumstances is based on the base unit value assigned to the surgical procedure plus time units and eligible modifying units (if any). Medically directed CRNA services will be paid at 50% of the calculated payment. A separate charge for the medical direction by a physician will be considered, up to the remaining 50%, when billed by the physician. When a CRNA is **not** medically directed, the full allowed rate is considered payable to the CRNA.

Aetna will not pay more than 100% of the total eligible calculated payment for the combined medical direction and CRNA services.

Medical Direction & Supervision of Anesthesia Administration

Aetna does consider the personal medical direction by a physician or anesthesiologist of a qualified Certified Registered Nurse Anesthetist (CRNA) as eligible for payment. When billing for the medical direction of anesthesia procedures, the following HCPCS modifiers should be used:

- **AD** – Medical supervision by a physician: more than four concurrent anesthesia procedures
- **QK** – Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals
- **QY** – Medical direction of one certified registered nurse anesthetist (CRNA) by an Anesthesiologist

Payment for the administration of anesthesia under these circumstances is based on the base unit value assigned to the surgical procedure plus time units and eligible modifying units (if any). Payment for the physician or anesthesiologist's medical direction service is determined on the basis of up to 50% of the allowance of the procedure performed. A charge for the medically directed or supervised CRNA service will be considered, up to the remaining 50%, when billed separately.

Aetna will not pay more than 100% of the total eligible calculated payment for the combined medical direction/supervision and CRNA services.

Monitored Anesthesia Care (MAC)

Based on input from academic societies and anesthesiologists in the provider community regarding MAC services, Aetna will allow coverage for MAC services when performed in an inpatient or outpatient setting. When reporting MAC, **always** use one of the following HCPCS modifiers:

- **QS** – Monitored anesthesia care service
- **G8** – Monitored anesthesia care for deep complex, complicated, or markedly invasive surgical procedure
- **G9** – Monitored anesthesia care for patient who has a history of severe cardiopulmonary disease

Since clear and complete documentation is a factor in the provision of quality care, Aetna will continue to monitor the appropriate use of the above MAC modifiers.

Unusual Anesthesia (CPT Modifier -23)

Under unusual circumstances, general anesthesia may be performed for procedures that typically require local or regional anesthesia or no anesthesia at all. The modifier "23" should be submitted with the appropriate procedure code to report unusual anesthesia. This modifier should not be reported with procedure codes that include the term "without anesthesia" in the description or for procedures that are normally performed under general anesthesia.

Aetna will review unusual anesthesia claim submissions on an individual consideration basis and will provide payment for medically necessary services at the allowance rate of three base units per procedure plus time units and eligible modifying units (if any). Documentation to support the reported service must be provided with the claim.