network RAPID UPDATE

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ANESTHESIA REIMBURSEMENT CHANGES EFFECTIVE SEPTEMBER 1 AND NOVEMBER 1, 2006 FOR ANTHEM BLUE CROSS AND BLUE SHIELD IN INDIANA, KENTUCKY AND OHIO

In response to valuable input from our providers, we are making changes to the method of reimbursement for Anesthesiologists and to our Anesthesia policies. September 1, 2006 Changes

Modifiers:

Effective September 1, 2006 Anthem Blue Cross and Blue Shield in Indiana, Kentucky, and Ohio will recognize the servicing modifiers for all products. The servicing modifiers are listed below. We already utilize these modifiers for processing Medicare Advantage products and will now allow them for all business.

Modifiers to be submitted by physicians include:

AA - Anesthesia services personally performed by anesthesiologist. 100% of the contracted rate is reimbursed to the anesthesiologist. This is not a required modifier.
QY – Medical direction of one CRNA/AA by an anesthesiologist. 50% of the contracted rate is reimbursed to the anesthesiologist. This is a required modifier to indicate supervision of a CRNA or Anesthesia Assistant.
QK –Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals. 50% of the contracted rate is reimbursed to the anesthesiologist. This is a required modifier to indicate supervision of two to four CRNAs or Anesthesia Assistants.
AD – Pay three time units only -- Medical supervision by a physician: more than four concurrent anesthesia procedures. This is a required modifier to indicate supervision of more than four CRNAs or Anesthesia Assistants.

Modifiers to be submitted by the CRNA or Anesthesia Assistant include:

QZ –CRNA/AA without medical direction by physician. 100% of the contracted rate is reimbursed to the CRNA/AA. This is not a required modifier.
QX –CRNA/AA with medical direction by a physician. 50% of the contracted rate is reimbursed to the CNRA/AA. This is a required modifier to indicate supervision from an Anesthesiologist.

Guideline for Anesthesia Services

Anthem is also updating our Anesthesia Services Clinical Guidelines, which can be obtained by contacting Provider Inquiry. This guideline is used in medical review determinations by Anthem Blue Cross and Blue Shield. For endoscopic or related anesthesia services, please note:

The routine assistance of an Anesthesiologist or Certified Registered Nurse Anesthetist (CRNA) for average risk patients undergoing standard upper and/or lower gastrointestinal endoscopic procedures is considered ***not medically necessary****.*

This policy is consistent with a joint statement published by the American College of Gastroenterology, American Gastroenterological Association and American Society for Gastrointestinal Endoscopy in 2004. In general, diagnostic and uncomplicated therapeuticendoscopy and colonoscopy can be successfully performed with moderate (conscious) sedation.

As a result of this change, beginning on September 1, 2006 all claims for CPT codes 00740 and 00810, anesthesia for endoscopic procedures, will now be subject to medical review for compliance with this guideline.

Per the guideline, Anesthesia Services may be considered medically necessary during gastrointestinal endoscopic procedures in any of the following situations:

a. Prolonged or therapeutic endoscopic procedure requiring deep sedation; or

b. A history of or anticipated intolerance to standard sedatives; or

c. Increased risk for complication due to severe comorbidity (American Society of Anesthesiologists [ASA] class III physical status or greater. See Appendix for physical status classifications which can be found in the CPT manual.)

d. Patient of extreme age, under 1 year or over 70; or

e. Pregnancy; or

f. History of drug or alcohol abuse; or

g. Uncooperative or acutely agitated patients (e.g., delirium, organic brain disease, senile dementia); or

h. Increased risk for airway obstruction due to anatomic variant including any of the following:

- History of previous problems with anesthesia or sedation; or
- History of stridor or sleep apnea; or
- Dysmorphic facial features, such as Pierre-Robin syndrome or trisomy-21; or
- Presence of oral abnormalities including but not limited to a small oral opening (less than 3 cm in an adult), high arched palate, macroglossia, tonsillar hypertrophy, or a non-visible uvula; or
- Neck abnormalities including but not limited to short neck, obesity involving the neck and facial structures, limited neck extension, decreased hyoid-mental distance (less than 3 cm in an adult), neck mass, cervical spine disease or trauma, tracheal deviation, or advanced rheumatoid arthritis; or
- Jaw abnormalities including but not limited to micrognathia, retrognathia, trismus, or significant malocclusion.

Predeterminations may be requested for anesthesia with standard upper and/or lower gastrointestinal endoscopic procedures. Please check the member's card for the number to call for pre-authorizations and request a predetermination

Anesthesia Procedure Codes

To improve claim processing and accurate adjudication when submitting claims for the administration of Anesthesia, please use the five digit anesthesia procedure codes (00100-01999). Anesthesia reimbursement will no longer be allowed on the five digit surgical CPT codes.
When the actual surgical procedure is performed by the anesthesiologist then reimbursement will be based upon the fee schedule and no base or time unit will apply. Examples of this include line placement, pain management, etc.

Physical Status Modifiers
Additional reimbursement for physical status modifiers are as follows. (excluding Medicare Advantage Products).

Modifier P3 = *1 unit* (A patient with severe systemic disease)

Modifier P4 = *2 units* (A patient with severe systemic disease that is a constant threat to life)

Modifier P5 = *3 units* (A moribund patient who is not expected to survive without the operation)

No additional reimbursement is allowed for:

Modifier P1 = A normal, healthy patient

Modifier P2 = A patient with mild systemic disease

Modifier P6 = A declared brain-dead patient whose organs are being removed for donor purposes

Multiple Modifiers
For appropriate claims adjudication, use Modifier 99 to indicate multiple modifiers in the first position when P3, P4, or P5 is being used in conjunction with QY, QK, AD or QX. (Example: modifier 99 in the first position, QY in the second, and P3 in third.)

Sample of CMS-1500 form - Section 24.A-D

24. A						B	C	D			
Date(s) of service						Place of Service	Type of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			
MM	DD	YY	MM	DD	YY			CPT/HCPC	Modifier		
02	01	06				23	4	00790	99	QY P3	

If a physical status modifier is being used with AA or QZ, place the physical status modifier in the first position. Modifier AA and QZ are not required modifiers for adjudication.

November 1, 2006 Change

Rounding Time Units
To provide more accurate reimbursement based upon time spent administering anesthesia we will no longer be rounding to next whole time unit. Rounding will be done to the next highest tenth (one decimal place). Example: 61 minutes / 15 = 4.0666 units will be rounded to 4.1 units instead of 5 units. To calculate the allowable amount: (Base units +Time units rounded to the nearest tenth) x contracted conversion factor = Maximum Allowable Amount.Please contact your Network Representative or Provider Inquiry with any questions on the above changes.

Anthem's reimbursement, if any, is reduced by any applicable deductibles, copayments and/or coinsurance as defined in the member's contract for benefits and coverage.