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AETNA BETTER HEALTH® OF KENTUCKY

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To: Network Providers **Fax:** <<location fax>>

In the News: **1. Aetna Better Health of Kentucky Policy Updates for Anesthesia**

NEW POLICY UPDATES

CLINICAL PAYMENT, CODING AND POLICY CHANGES

We regularly augment our clinical, payment and coding policy positions as part of our ongoing policy review processes. In an effort to keep our providers informed, please see the below chart of upcoming new policies.

Effective for dates of service beginning **September 25, 2018**:

Anesthesia Policies
Anesthesia Crosswalk-According to our policy, which is based on guidelines from the American Society of Anesthesiologists, anesthesia services should be reported with the appropriate anesthesia CPT codes and not the surgical code.
Anesthesia for Deliveries-According to our policy, it is unlikely that a subsequent delivery occurred within an 8-month period following a previously reported cesarean delivery.
Anesthesia for Gastrointestinal Endoscopic Procedures-According to our policy which is based on American Society of Gastrointestinal Endoscopy practice guidelines, routine gastrointestinal endoscopy procedures in average-risk patients will usually not require anesthesiology assistance in the form of monitored anesthesia care or general anesthesia.
Anesthesia for Pain Management Injections-According to our policy, which is based on guidelines from the American Society of Anesthesiologists and the International Spine Intervention Society, minor pain procedures, under most routine circumstances, do not require anesthesia care other than local anesthesia.
Anesthesia Modifiers for Anesthesia Services- -According to our policy, which is based on CMS Policy, physicians must report the appropriate anesthesia modifier to denote whether the service was personally performed, medically directed, medically supervised or represented monitored anesthesia care. -According to our policy, which is based on CMS Policy, it is not appropriate to bill multiple anesthesia modifiers on the same claim line; it would not be expected to see more than one anesthesia modifier appended to the same claim line as these modifiers are mutually exclusive.
Certified Registered Nurse Anesthetist (CRNA) Services-According to our policy, which is based on CMS policy, anesthesia services provided by a CRNA are to be billed with the appropriate modifier to designate whether the service was performed with or without medical direction by a physician.

Daily Management of Epidurals with Qualifying Circumstance Codes and Physical Status Modifiers-

-According to our policy, which is based on the American Society of Anesthesiologists Relative Value Guide, daily hospital management of epidural or subarachnoid continuous drug administration should not be reported with qualifying circumstances codes 99100-99140.

-According to our policy, which is based on the American Society of Anesthesiologists Relative Value Guide, daily hospital management of epidural or subarachnoid continuous drug administration should not be reported with physical status modifiers P1-P6.

Duplicate Anesthesia Services on the Same Day-

-According to our policy, which is based on CMS policy, modifiers QX (CRNA service with medical direction by a physician) and QZ (CRNA service without medical direction by a physician) indicate that the procedure was performed by a CRNA. Therefore, it is inappropriate for an anesthesiologist to bill the same procedure with modifier AA (Anesthesia services performed personally by anesthesiologist) indicating that the procedure was performed personally by the anesthesiologist.

-According to our policy, which is based on CMS Policy, modifier AA (Anesthesia services performed personally by anesthesiologist) indicates that the procedure was performed by an anesthesiologist. Therefore, it is inappropriate for a CRNA to bill the same procedure with modifiers QX (CRNA service with medical direction by a physician) or QZ (CRNA service without medical direction by a physician).

Frequency of Epidural and Facet Injections-According to CMS policy and our policy, patients in need of an epidural or subarachnoid injection should have this service administered no more frequently than 3 times in 6 months; paravertebral facet joint injections performed in the cervical or thoracic regions are limited to eight (8) times per year: up to eight (8) transforaminal epidural injection sessions per region may be performed in a 365 day period: up to two (2) diagnostic and up to six (6) therapeutic.

Multiple General Anesthesia Services on Same Day-According to our policy, which is based on CMS Guidelines, only one anesthesia code is reported unless the anesthesia code is an add-on code or has an appropriate modifier attached. Therefore, only the anesthesia service which has the highest base unit value should be reported. This policy applies to both professional and outpatient facility services.