Payment Policy

Subject: Anesthesia

Programs Covered: OH Medicaid, KY Medicaid, OH MyCare, and Just4Me™ (all states)

Effective Date: 6/1/2013

Policy

CareSource will reimburse for medically necessary anesthesia procedures rendered within scope of practice in a physician's office, inpatient or outpatient facility.

Definitions

"**Anesthesia time**" is the actual number of anesthesia minutes as reported on the claim. Anesthesia time begins when the anesthetist begins to prepare the patient for the induction of anesthesia in the operating room or in an equivalent area and ends when the anesthetist is no longer in personal attendance, that is, when the patient may be safely placed under post-anesthetic supervision. *(from OAC 5160--4-21 (B)(4))*

"**Base unit**" means the value for each anesthesia code that reflects all activities other than anesthesia time. Anesthesia activities include usual pre-operative and post-operative visits, the administration of fluids or blood incident to anesthesia care, and monitoring services. *(from OAC 5160-4-21 (B)(1))*

"**Base unit value**." Each anesthesia code (procedure codes 00100-01999) is assigned a base unit value by the American Society of Anesthesiologists (ASA) and used for the purpose of establishing fee schedule allowances. Anesthesia services are paid on the basis of a relative value system, which include both base and actual time units. Base units take into account the complexity, risk, and skill required to perform the service. (from http://www.cms.hhs.gov)

"**Medical direction**" is when a physician utilizes the assistance of a CRNA/AA, resident, intern, or fellow in the performance of the aesthesis services and is involved in no more than four concurrent anesthesia cases. *(from OAC 5160-4-21 (C)(3)(a))*

"**Medical supervision**" is when the physician anesthesiologist is involved in furnishing services for more than four concurrent procedures or is performing other services while directing the concurrent procedures. In situations where the physician is involved in medically supervising more than four procedures concurrently, or is performing other services while directing the concurrent procedures, the physician must be involved in the pre-surgical anesthesia services. *(from OAC 5160-4-21 (C)(3)(b) and (4))*

"**Monitored Anesthesia Care**" (MAC) is a combination of local anesthesia and certain anxiolytic and analgesic medications. When this type of anesthesia is used, the patient maintains protective reflexes and consciousness except for a brief period of time. *(from OAC 5160-4-21 (I))*

"**Time unit**" means the continuous actual presence of the physician (or of the medically-directed resident or medically-directed CRNA/AA) and starts when he/she begins to prepare the patient for anesthesia and ends when the anesthesiologist (or medically-directed CRNA/AA) is no longer in personal attendance with the exception of anesthesia for neuraxial analgesia for obstetrical services. *(from OAC 5160-4-21 (B)(3))*

"**Time unit value**" means one unit for each fifteen minutes of reported anesthesia time. Since only the actual time of a fractional time unit is recognized, the resulting time unit value will be rounded to one decimal place. *(from OAC 5160-4-21 (B)(5))*

Provider Reimbursement Guidelines

Prior Authorization

Prior authorization for anesthesia services may be required depending on place of service.

CareSource will reimburse a qualified provider for general, regional, or supplementation of local anesthesia services (or monitored anesthesia care services as described below) provided during a surgical or diagnostic procedure. Anesthesia services include the usual pre-operative and post-operative visits, the anesthesia care during the procedure, the administration of fluid and/or blood products incident to the anesthesia or surgery, and the basic monitoring procedures. ECG, temperature, blood pressure, oximetry, capnography and mass spectometry are considered usual monitoring procedures. Unusual monitoring procedures such as intra-arterial, central venous and Swan Ganz are not included in the payment for anesthesia services and may be separately billed and reimbursed.

Provider

CareSource will reimburse a qualified provider for anesthesia services only if that provider is acting exclusively as an anesthetist and is not also acting as the surgeon or assistant surgeon. An exception would be if a provider employs a Certified Registered Nurse Anesthetist ("CRNA") to provide anesthesia services. In that case, the provider may bill and receive reimbursement for the services of the CRNA in addition to the reimbursement for the surgical procedures performed by the attending physician.

For each patient, the provider must:

a) Perform a pre-anesthetic examination and evaluation;

b) Prescribe the anesthesia plan;

c) Personally participate in the most demanding procedures in the anesthesia plan, including induction and emergence;

d) Ensure that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual;

e) Monitor the course of anesthesia administration at frequent intervals;

f) Remain physically present and available for immediate diagnosis and treatment of emergencies; and

g) Provide indicated post-anesthetic care.

The provider may either personally perform the services itemized above, without the assistance of a CRNA/AA, resident, intern, fellow, or other qualified anesthetist, or the provider may use the assistance of a CRNA/AA, resident, intern, fellow or other qualified anesthetist in the performance of these services, and not perform any other services while providing medical direction.

For physician-directed/supervised CRNA/AA services, providers should submit the appropriate procedure code, modifier and applicable time units for both the physician and CRNA/AA on separate claim lines. Submit the primary anesthesia service as the first claim line.

CareSource will not compensate E&M services when invoiced with anesthesia services, as the E&M service is included in the anesthesia service. Submitting a separate E&M service in place of a physician is appropriate if the only service provided was a pre-operative evaluation and no anesthesia was administered. Submitting an E&M procedure code for a pre-operative consultation is not appropriate unless the surgery is cancelled subsequent to the pre-operative visit.

CareSource will reimburse for anesthesia services for a teaching anesthesiologist involved in an anesthesia procedure with a resident. The teaching physician must document in the medical records that he/she was present during all critical or key portions of the procedure. The teaching physician's physical presence during only the preoperative or post-operative visits with the patient is not sufficient to receive reimbursement.

Time & the Reimbursement Formula

Providers must report the start and end time for the administration of anesthesia, as well as the total number of minutes that anesthesia services were rendered. For example, if the total time of anesthesia was two (2) hours and ten (10) minutes, services should be submitted at 130 minutes. Every 15-minute interval will be converted by CareSource into 1 unit, rounding up to the next unit for 8 to 14 minutes, rounding down for 1 to 7 minutes. Claims submitted in units will be rejected.

During claims processing, submitted minutes will be converted to time units. The formula for calculating the reimbursement of anesthesia services will be the base unit value and the time unit value multiplied by the appropriate conversion factor, if any, or percentage of a conversion factor, as applicable.

The following formula exceptions apply:

- Pain-management physicians are sometimes called in to manage postoperative patients who received an epidural catheter during surgery, which is indicated with CPT code 01996 (*daily management of epidural or subarachnoid drug administration*). Anesthesia code 01996 will be paid based on the base units specified in the relative value guide. No calculation for time is allowable for this anesthesia code;
- Services invoiced with the "AD" modifier will be paid at three times the appropriate conversion factor, if any.

No additional reimbursement will be paid for the physical status of the patient, the age of the patient, body hypothermia, body hyperthermia, emergency conditions, or time of day.

Reimbursement for monitored anesthesia care is the same as for general anesthesia when all of the conditions for reimbursement are met. There is no additional reimbursement for monitored anesthesia.

CPT Codes and Modifiers

The following anesthesia modifiers must be used for anesthesia services:

- **AA** Anesthesia services personally performed by the anesthesiologist. The modifier "AA" may be used if a teaching anesthesiologist is continuously involved in one procedure with one resident or with one student certified registered nurse anesthetist. The teaching anesthesiologist must document in the medical records that he or she was present during all critical portions of the procedure including induction and emergence.
- **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;
- **QX** CRNA with medical direction by a physician or anesthesia assistant with medical direction by an anesthesiologist;
- **QY** Medical direction of one CRNA by an anesthesiologist; and
- **QZ** CRNA without medical direction by physician.

Note: Anesthesiologist assistants may use the modifier "QX" for services provided under the medical direction of an anesthesiologist if they are employed by a physician or in an independent practice. An anesthesiologist may use the "QY" modifier if he/she provides medical direction to an anesthesiologist assistant.

When it is medically necessary to provide general anesthesia services for extensive restorative dental procedures or for a covered oral surgery procedure for which there is not a surgical code, the anesthesia services must use code 00170 modified by the appropriate anesthesia modifier.

For the reimbursement of anesthesia services the provider must use the anesthesia code that best describes the anesthesia procedure performed modified by the appropriate anesthesia modifier, and report the total anesthesia time in minutes.

Surgical CPT codes that include the administration of anesthesia in the description of that CPT code will only be reimbursed when an anesthesia CPT code in the range 00100-01999 is also coded on the claim. Certain CPT codes will not be reimbursed by CareSource because it is not considered to be a surgery or incident to another surgery. For this policy, CareSource follows the guidelines provided by OAC Rule 5160-2-21, "Policies for Outpatient Hospital Services," and applies the same exceptions identified in Appendix C of that Rule.

NOTE: Effective June, 1 2013 CareSource is no longer making exceptions to this policy for CPT codes 64479/64480 and 64483/64484. CareSource previously excluded these codes from the logic of this policy; however this was rescinded because Primary/Secondary logic does not apply to facility coding, making that exclusion incorrect.

Related Policies & References

OAC Rule 5160-2-21 Policies for Outpatient Services / Surgical Claim Edits

OAC 5160-4-05 (E) (1) (i)

OAC Rule 5160-4-21 Physician Services / Anesthesia Services

201 KAR 8:550. Anesthesia and sedation.

907 KAR 3:010. Reimbursement for physicians' services - Sections 3 & 4

Document Revision History

10/31/2013 – OAC Rules renumbered from “5101:3-2-21,” “5101:3-4-5(E)(1)(i),” and “5101:3-4-21,” per Legislative Service Commission Guidelines.

1/26/2015 - Updated, effective 6/1/2013 exception is no longer being made for certain CPT codes (from Network Notification (June 2012)); updated references to OAC rules**.**