REIMBURSEMENT POLICY STATEMENT
Ohio Medicaid

Policy Name & Number	Date Effective
Monitored Anesthesia Care-OH MCD-PY-1685	11/01/2025
Policy Type	
REIMBURSEMENT	

Reimbursement Policies prepared by CareSource and its affiliates are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination. CareSource and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject
Monitored Anesthesia Care

B. Background
ICD-10 guidelines are a set of rules regarding the classification of diagnoses and reasons for health care visits in all settings based on the statistical classification of disease published by the World Health Organization. The guidelines are approved by the American Hospital Association (AHA), the American Health Information Management Association (AHIMA), the Centers for Medicare and Medicaid Services (CMS), and the National Center for Health Statistics (NCHS). Under the Health Insurance Portability and Accountability Act (HIPAA), adherence to these guidelines is mandatory.

Code assignment is based on the provider's documentation outlining the relationship between the condition and the care or procedure, unless otherwise instructed by the classification. There must be a cause-and-effect relationship between the care provided and the condition. In addition to general coding guidelines, there are guidelines for specific diagnoses and/or conditions in the classification. Unless otherwise indicated, these guidelines apply to all health care settings.

Current Procedural Terminology (CPT) codes are the official code set for compliance mandated by HIPPA for healthcare procedures and services and are developed and maintained by the American Medical Association (AMA). CPT includes the use of modifiers to clarify the service reported and increase reimbursement accuracy and coding consistency. In billing, medical necessity is demonstrated by the diagnosis code assigned and whether the documented elements are consistent with the problems addressed (CPT).

The Medicaid National Correct Coding Initiative (NCCI) aims to reduce improper payments in the Medicaid program and includes edits for Procedure-to-Procedure (PTP), Medically Unlikely Edits (MUE), and Add-on Code (AOC). Claims denied by NCCI edits are based on a determination of inappropriate coding and not on the basis of medical necessity. Clinical judgment is not needed to deny a claim based on correct coding.

Certain surgical procedures may include anesthesia services as part of a global fee. In such cases, procedure-to-procedure edits may prevent separate billing for monitored anesthesia care (MAC) when it is not allowed. These edits help ensure that claims for anesthesia services are consistent with clinical guidelines and that services billed together are appropriate. CareSource follows guidance from the Ohio Dept of Medicaid (ODM) for payment of MAC.

C. Definitions
- **Anesthesia Services** – The administration of any drug or combination of drugs to create deep sedation/analgesia, regional anesthesia or general anesthesia but does not include topical or local anesthesia or moderate sedation/analgesia.

- **Claim** – A bill from a provider for health care services assigned a unique identifier, including a bill for services, a line item of services and/or all services for one member within a bill.
- **Edit** – Adjusting 1 or more procedure codes billed by a participating provider on a claim for payment or a practice that results in
  - Payment for some but not all of the procedure code originally billed.
  - Payment for a different procedure code than the procedure code originally billed.
  - A reduced payment as a result of services claimed under more than 1 procedure code on the same service date.
- **Office Setting** – An office or portion thereof utilized to provide medical and/or surgical services to the physician's own patients but not including an office or portion thereof licensed as an ambulatory surgical facility pursuant to ORC 3702.30, a registered hospital pursuant to ORC 3701.07 or an emergency department located within such a hospital.
- **Procedure Codes** – The AMA's CPT code, the American Dental Association's Current Dental Terminology, and CMS's Health Care Common Procedure Coding System (HCPCS).
- **Provider** – A physician or any qualified healthcare practitioner who is legally accountable for establishing a member's diagnosis.

D. Policy

I. General Reimbursement Guidelines

A. All claims for MAC are to be submitted in accordance with established guidelines managed by the Ohio Administrative and Revised Codes (OAC and ORC, respectively), particularly as related to OAC 5160-4-21.

B. In accordance with the ODM, claims are to be submitted pursuant to the NCCI and coding standards set forth in the following guides:
   1. *Healthcare Common Procedure Coding System*
   2. *Current Procedural Terminology Codebook*
   3. *Current Dental Terminology Codebook*
   4. *Internal Classification of Diseases Handbook*

C. When adjudicating claims, CareSource utilizes code editing software to evaluate the accuracy of diagnoses and procedure codes to ensure that claims are processed consistently, accurately, and efficiently. The software evaluates accuracy of the procedure code only, not medical necessity for the procedure. The edits utilized include
   1. Medicaid NCCI
   2. ICD-10 guidelines
   3. CPT guidelines
   4. HCPCS guidelines
   5. CMS published materials, as applicable
   6. state published reimbursement guidelines
   7. state and federal statutes and regulations

D. Per correct coding, the ICD-10 diagnosis and the CPT/HCPCS code demonstrate the cause-and-effect relationship of the condition and care provided. Claims may be denied due to an improper grouping of codes.
E. It is the provider's responsibility to select codes carried out to the highest level of specificity and selected from the ICD-10-CM code book appropriate to the year in which the service is rendered for the claim(s) submitted. The provider must also use applicable modifiers, as necessary, including those that indicate whether a procedure was personally performed, medically directed or medically supervised.

II. MAC
A. MAC should be provided by qualified anesthesia personnel continuously present to monitor the member and provide care in accordance with state licensure requirements.
B. During MAC, the attending anesthetist should assess the member's oxygenation, ventilation, circulation, and temperature using the most appropriate methods available, including advanced non-invasive monitoring techniques. Close observation is essential to foresee the need for administering general anesthesia or addressing adverse physiological reactions. The potential for the procedure to become more complex or lead to unexpected complications necessitates thorough monitoring and possible anesthetic intervention.
C. Certain anesthesia procedures are typically performed by the attending surgeon and are included in the global fee, not billed separately. However, in specific cases, MAC may be deemed reasonable and necessary for procedures usually handled by the attending surgeon, provided certain conditions exist. In these scenarios, MAC may be essential to address serious accompanying conditions and ensure a smooth anesthesia process (and surgery) by preventing adverse physiological complications. It is important that any special conditions or criteria are documented in the medical record.
D. High-quality MAC is essential and demands the same level of expertise and effort as administering general anesthesia. If the necessary criteria are not met or if the procedures are deemed unnecessary, full payment may be denied.
E. For procedures that typically do not necessitate anesthesia services, MAC may be covered if the member's condition warrants qualified anesthesia personnel to provide monitoring alongside the physician performing the procedure. This must be documented in the medical record.
F. The presence of an underlying condition may not be adequate justification for the necessity of MAC. The medical condition must be substantial enough to require MAC (eg, member being on medication, member exhibiting symptoms). Simply having a stable, managed condition is not, by itself, sufficient.
G. No additional payment will be made on account of physical status, age, body temperature (hypothermia or hyperthermia), emergency conditions or time of day.

E. Conditions of Coverage

I. Anesthesia services must be submitted with at least 1 CPT anesthesia code. These codes are reimbursed based on time units using the standard anesthesia formula.

II. All documentation must be maintained in the medical record and made available upon request, including the following:
   A. legible pages with appropriate member identification information (eg, complete name, dates of service[s])
   B. legible signature of the physician or non-physician practitioner responsible for and providing care
   C. support for medical necessity of the services and selected ICD-10 code(s) and CPT/HCPCS codes performed/used
   D. the reason for MAC
   E. a pre-anesthesia evaluation, including a history and physical exam
   F. evidence of continuous monitoring of member oxygenation, ventilation, circulation, and temperature
   G. a post-anesthesia evaluation, including any unusual events or complications
   H. member status on discharge

III. Required anesthesia modifiers may include the following, which are provided as a courtesy only:

Modifier	Provider Type
AA	Anesthesiologist physician, personally performed
AD	Anesthesiologist physician, supervising over 4 qualified non-physician anesthetists performing concurrent anesthesia procedures
QK	Anesthesiologist physician, supervising 2-4 qualified non-physician anesthetists performing concurrent anesthesia procedures
QS	Monitored anesthesia care reported with an anesthesia procedure code
QX	CRNA or AA directed by anesthesiologist physician
QY	Anesthesiologist physician, supervising 1 qualified non-physician anesthetist
QZ	CRNA, personally performed

F. Related Policies/Rules

NA

G. Review/Revision History

	DATE	ACTION
Date Issued	07/16/2025	New policy. Approved at Committee.
Date Revised		
Date Effective	11/01/2025	
Date Archived		

H. References

1. *2025 ICD-10-CM Official Guidelines for Coding and Reporting*. AAPC; 2025.

2. American Medical Association CPT Editorial Panel. *cpt© 2025 Professional Edition*. American Medical Association; 2024.
3. Anesthesia Services, OHIO ADMIN. CODE 5160-4-21 (2024).
4. CPT codes. American Medical Association. Accessed June 5, 2025. www.ama-assn.org
5. Health Care Contracts Definitions, OHIO REV. CODE § 3963.01 (2024).
6. *Medicaid NCCI Coding Policy Manual*. Centers for Medicare and Medicaid Services; 2025.
7. Office Based Surgery, OHIO ADMIN. CODE Chapter 4731-25 (2024).
8. Ohio Medicaid Provider Agreement for Managed Care Organization. The Ohio Dept of Medicaid. Revised January 2025.
9. *Provider Manual – Ohio Medicaid*. CareSource; 2024. Accessed June 16, 2025. www.caresource.com
10. Submission of Medicaid Claims, OHIO ADMIN. CODE 5160-1-19 (2023).

Approved by Ohio Department of Medicaid 08/05/2025