CareSource

# REIMBURSEMENT POLICY STATEMENT
# Ohio Medicaid

| Policy Name & Number | Date Effective |
|---|---|
| Monitored Anesthesia Care-OH MCD-PY-1685 | 11/01/2026 |
| **Policy Type** | |
| **REIMBURSEMENT** | |

Reimbursement Policies 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. Reimbursement Policies do not guarantee authorization or payment for services. Coverage and payment determinations are subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreements, and applicable referral, authorization, notification, and utilization management guidelines.

Please refer to the plan contract (e.g., Evidence of Coverage, Member Handbook) for the service(s) referenced herein. Except as otherwise required by law, if there is a conflict between the Reimbursement Policy and the plan contract and/or provider agreement, then the plan contract and/or provider agreement will be the controlling document used to make the determination. Reasonable discretion may be used in interpreting and applying this policy to services provided in a particular case and the policy may be modified at any time. Reimbursement policies may be superseded by federal and state laws and regulations, as applicable. In the case of a discrepancy between the Policy Statement's effective date and any applicable legal or regulatory requirement, the law or regulation will govern.

Coverage for mental health and substance use disorder (MH/SUD) benefits are provided at the same level as coverage for medical and surgical (M/S) benefits, as required by the Mental Health Parity and Addiction Equity Act (MHPAEA). MH/SUD benefits are not subject to limits or requirements that are more restrictive than those that apply to M/S benefits.

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A. Subject
**Monitored Anesthesia Care**

B. Background
ICD-10 guidelines establish rules for classifying diagnoses and reasons for health care visits in all settings based on the World Health Organization's statistical classification of diseases. 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). Compliance with guidelines is required under the Health Insurance Portability and Accountability Act (HIPAA).

Code assignment is based on the provider's documentation of the relationship between the condition and the care or procedure, unless classification instructs otherwise. A clear cause-and-effect relationship must exist between the care provided and the condition. In addition to general coding guidelines, the classification includes guidelines for specific diagnoses and/or conditions. Unless otherwise indicated, these guidelines apply to all health care settings.

Current Procedural Terminology (CPT) codes are the official code set required under HIPPA for reporting healthcare procedures and services and are developed and maintained by the American Medical Association (AMA). CPT also includes modifiers to clarify the service reported and support greater coding consistency and reimbursement accuracy. In billing, medical necessity is demonstrated by the diagnosis code assigned and whether the documented elements support the problems addressed.

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 Codes (AOC). Claims denied under NCCI edits are based on a determination of inappropriate coding and not on the basis of medical necessity. Clinical judgment is not required to deny a claim based on correct coding.

Certain surgical procedures may include anesthesia services in a global fee. In such cases, procedure-to-procedure edits may prevent separate billing for monitored anesthesia care (MAC) if separate reimbursement 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.

- **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.
- **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 coding accuracy only and does not determine 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 to the highest level of specificity from the ICD-10-CM code book appropriate to the year in which the service is rendered for claims submitted. The provider must use applicable modifiers, as necessary, including those indicating whether a procedure was personally performed, medically directed or medically supervised.

II. MAC
   A. MAC must 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 identify possible need to convert to general anesthesia or respond to adverse physiological reactions. Because the procedure may become more complex or unexpected complications may arise, thorough monitoring and prompt anesthetic intervention must be maintained throughout.
   C. Certain anesthesia procedures are typically performed by the attending surgeon and are included in the global fee, not billed separately. In specific cases, MAC may be reasonable and necessary for procedures usually handled by the attending surgeon, provided certain conditions exist (ie, minor local surgery, routine procedures minor in nature, emergency urgent exceptions). In these scenarios, MAC may be essential to address serious accompanying conditions and reduce the risk of adverse physiological complications during the procedure. Any special conditions or criteria must be documented in the medical record, especially situations involving life-threatening emergencies to members.
   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, may not be all-inclusive and are subject to change:

| 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** | 07/01/2026 | Annual review. Updated references. Approved at Committee. |
| **Date Effective** | 11/01/2026 | |
| **Date Archived** | | |

## H. References

1. *2026 ICD-10-CM Official Guidelines for Coding and Reporting*. AAPC; 2026.
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 9, 2026. 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; 2026.
7. Office Based Surgery, OHIO ADMIN. CODE Chapter 4731-25 (2024).

8. Ohio Medicaid Provider Agreement for Managed Care Organizations. The Ohio Dept of Medicaid. Accessed June 9, 2026.
9. *Provider Manual – Ohio Medicaid*. CareSource; 2025. Accessed June 9, 2026. www.caresource.com
10. Submission of Medicaid Claims, OHIO ADMIN. CODE 5160-1-19 (2023).

*Approved by Ohio Department of Medicaid 08/04/2026*