Anesthesia Services Payment Policy

Policy Statement

Anesthesia services include but are not limited to general anesthesia, regional anesthesia, supplementation of local anesthesia, or other supportive services in order to afford the patient the anesthesia care deemed optimal by the anesthesiologist or certified nurse anesthetist during any procedure.

Scope

This policy applies to:

☒**Medicaid** *excluding Extended Family Planning (EFP)*
☒**INTEGRITY**
☒**Commercial**

Prerequisites

All services must be medically necessary to qualify for reimbursement. Neighborhood may use the following criteria to determine medical necessity:

- National Coverage Determination (NCD)
- Local Coverage Determination (LCD)
- Industry accepted criteria such as Interqual
- Rhode Island Executive Office of Health and Human Services (EOHHS) recommendations
- Clinical Medical Policies (CMP)

It is the provider's responsibility to verify eligibility, coverage and authorization criteria prior to rendering services.

For more information please refer to:

- Neighborhood's plan specific Prior Authorization Reference page.
- Neighborhood's Clinical Medical Policies.

Please contact Provider Services at 1-800-963-1001 for questions related to this policy.

Reimbursement Guidelines

Neighborhood will reimburse covered, medically necessary anesthesia services performed in conjunction with covered authorized surgical procedures when performed by qualified and licensed medical doctor and certified registered nurse anesthetist (CRNA). Out-of-network providers may require separate authorization when billing separately.

Services Included in Global Anesthesia Care (not reimbursed separately)

- Anesthesia that is integral to the surgical procedure
- Evaluation and management for post op pain management or routine pre or postop anesthesia service.
- Post-operative pain management on the same day as surgical procedure
- Maintenance of open airway and ventilator measurements and monitoring
- Monitoring of electrocardiograms (EKGs), pulse breathing, blood pressure, electroencephalogram and other neurological monitoring;
- Monitoring of left ventricular or valve function via transesophageal echocardiogram (TEE);
- Monitoring of intravascular fluids (IVs), blood administration and fluids used during cold cardioplegia through non-invasive means;
- Anesthetic or analgesic administration;
- Local anesthesia during surgery

Anesthesia claims are paid based on the following:

Time units + Base unit x Anesthesia Conversion factor. Neighborhood uses the Centers for Medicare and Medicaid Services (CMS) base unit values.

- Anesthesia Personally Performed by Anesthesiologist or CRNA (AA or QZ Modifier) (Total Time Units + Base Unit) x Anesthesia Conversion Factor x Modifier Adjustment = Allowance
- Anesthesia Performed under Medical Direction (QK, QX and QY modifiers) [(Total Time Units + Base Unit) x Anesthesia Conversion Factor] x Modifier Adjustment = Allowance for each provider

Anesthesia start time is defined as the time the anesthesiologist begins the preparation of the patient. Anesthesia end time is defined as the time when the patient is placed under post-operative care. Time anesthesiologist is not in personal attendance is non-billable. Do not submit base unit values in the total minutes or units field on a claim. Base units are automatically calculated and paid in Neighborhood reimbursement.

Obstetrical Anesthesia Services

Reimbursement for the following codes will be capped at the time units listed no matter the time units billed. Provider must continue to bill the actual time the service was rendered. Neighborhood will apply the cap during processing.

- Vaginal delivery code 01967 is capped at a maximum of 28 units or 420 minutes
- Cesarean section delivery add-on code 01968 is capped at a maximum 4 units or 60 minutes

Multiple/Duplicate Anesthesia Services on the Same Day

Submit only the highest base-unit value service with the total time spent for all procedures when multiple anesthesia services are administered on the same patient on the same date of service. Duplicate services will not be reimbursed.

Exclusions

- Services billed by anesthesia assistants
- Services provided by students
- CRNA services performed by salaried facility employees
- Post-operative pain management on the same day as surgical procedure
- Anesthesia by the operating surgeon
- Anesthesia stand by
- Anesthesia for procedures not designated as requiring anesthesia
- Anesthesia for non-covered surgical procedures

Claim Submission

All claims for anesthesiologists and CRNAs must be billed under the name and National Provider Identifier (NPI) of the provider who actually rendered the service. "Incident to" billing for anesthesia services is not recognized by Neighborhood. All providers should render services based on the scope of their particular license.

Billable services are subject to contractual agreements, when applicable. Providers are required to submit complete claims for payment within contractually determined timely filing guidelines.

Coding must meet standards defined by the American Medical Association's Current Procedural Terminology Editorial Panel's (CPT®) codebook, the International Statistical Classification of Diseases and Related Health Problems, 10th revision, Clinical Modification (ICD-10-CM), and the Healthcare Common Procedure Coding System (HCPCS) Level II.

Documentation Requirements

General Documentation Requirements for all services:

- Type of anesthesia services performed, including exact time spent performing anesthesia services, must be documented in the anesthesia record to support billing.
- Procedure performed - This must match the surgeon's procedure dictated on the operative report.
- Rendering practitioner/qualified healthcare professional must note their credentials and legibly sign and date the record.

- Member identifying information must be present on all pages of the record. Patient positioning.
- Discontinuous time.
- Relief anesthesia providers – times when each anesthesia provider leaves or comes on to a case.
- Post operative pain management – surgeon request, start and stop times, location of block placement, type of regional anesthetic/peripheral nerve block.
- Documentation must be legible.

Medical Direction Documentation Requirements

For each anesthesia procedure, the anesthesiologist must document that he/she performed the following seven services and record each in the patient's anesthesia record:

1. A pre-anesthetic examination and evaluation;
2. Prescribe the anesthesia plan;
3. Personally participate in the most demanding procedures of the anesthesia plan including, if applicable, induction and emergence;
4. Ensure that any procedure in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist;
5. Monitor the course of anesthesia administration at frequent intervals;
6. Remain immediately physically present and available for immediate diagnosis and treatment of emergencies; and
7. Provide the indicated post-anesthesia care.

Medical Supervision Documentation Requirements

When the anesthesiologist does not fulfill all of the "medical direction" requirements listed above, the anesthesia services are considered medical supervision services. Documentation must indicate if the anesthesiologist was present at induction.

Neighborhood reserves the right to request medical records for any service billed. Documentation in the medical record must support the service(s) billed as well as the medical necessity of the service(s). Neighborhood follows CMS standards for proper documentation requirements.

Member Responsibility

Commercial plans include cost sharing provisions for coinsurance, copays, and deductibles. Members may have out of pocket expenses based on individual plan selection and utilization. Please review cost sharing obligations or contact Member Services prior to finalizing member charges.

Disclaimer

This payment policy is informational only and is not intended to address every situation related to reimbursement for healthcare services; therefore, it is not a guarantee of reimbursement.

Claim payments are subject to the following, which include but are not limited to: Neighborhood Health Plan of Rhode Island benefit coverage, member eligibility, claims payment edit rules, coding and documentation guidelines, authorization policies, provider contract agreements, and state and federal regulations. References to CPT or other sources are for definitional purposes only.

This policy may not be implemented exactly the same way on the different electronic claims processing systems used by Neighborhood due to programming or other constraints; however, Neighborhood strives to minimize these variations.

The information in this policy is accurate and current as of the date of publication; however, medical practices, technology, and knowledge are constantly changing. Neighborhood reserves the right to update this payment policy at any time. All services billed to Neighborhood for reimbursement are subject to audit.

Coding

CPT Code	Description
00100 to 01999	Anesthesia Services
62273	Injection, epidural, of blood or clot patch
99100	Anesthesia for patient of extreme age, younger than 1 year and older than 70 (List separately in addition to code for primary anesthesia procedure)
99116	Anesthesia complicated by utilization of total body hypothermia (List separately in addition to code for primary anesthesia procedure)
99135	Anesthesia complicated by utilization of controlled hypotension (List separately in addition to code for primary anesthesia procedure)
99140	Anesthesia complicated by emergency conditions (specify) (List separately in addition to code for primary anesthesia procedure)
99151	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient younger than 5 years of age
99152	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older

CPT Code	Description
99153	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes intraservice time (List separately in addition to code for primary service)
99155	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient younger than 5 years of age
99156	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient age 5 years or older
99157	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intraservice time (List separately in addition to code for primary service)

Modifier	Description	Percentage reimbursed (of fee schedule or allowance for procedure)
AA	Anesthesia services performed personally by anesthesiologist	100%
AD	Medical supervision by a physician: more than four concurrent anesthesia procedures	100%
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals	50%
QY	Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist	50%
QX	CRNA service: with medical direction by a physician	80% of remaining allowable

Modifier	Description	Percentage reimbursed (of fee schedule or allowance for procedure)
QZ	CRNA service: without medical direction by a physician	80%
P1	Normal healthy patient	No effect on reimbursement
P2	A patient with mild systemic disease	No effect on reimbursement
P3	A patient with severe systemic disease	No effect on reimbursement
P4	A patient with severe systemic disease that is a constant threat to life	No effect on reimbursement
P5	A moribund patient who is not expected to survive without the operation	No effect on reimbursement
P6	A declared brain-dead patient whose organs are being removed for donor purposes	No effect on reimbursement

***Modifiers that do not affect reimbursement should not be billed in the primary modifier position. Claims will deny if not billed appropriately.**

Document History

Date	Action
11/28/2023	Annual Policy Review Date. Clarified requirements regarding modifier usage
01/01/2023	Policy review. Format change. Removed General Billing Information. Added language for General Documentation Requirements.
6/1/2014	CRNA credentialing requirements effective Septemeber 2014, CRNA billing and reimbursement requirements effective October 2014, clarifying billing and coding information.
5/1/2014	Format change, clarifying billing and coding information, Epidural cap limits for 01967/01968 effective 8/1/2014, Disclaimer updated.
9/1/2013	Format change only
8/1/2011	Effective Date