Anesthesia Payment Policy

Policy

Fallon Community Health Plan (FCHP) reimburses for covered services including, but not limited to, general or regional anesthesia, supplementation of local anesthesia or other supportive services. These services include the usual preoperative and postoperative visits, the anesthesia care during the procedure, the administration of fluids and/or blood and the usual monitoring services (e.g. ECG, blood pressure, oximetry, temperature, capnography and mass spectrometry). Unusual forms of monitoring (e.g. intra-arterial, central venous, and Swan-Ganz) are not included and may be billed separately.

Definition

This policy defines FCHP's payment policy for anesthesia services. In some instances, FCHP provider contracts may include the provision of anesthesia services as defined in this policy. (Please note: We have incorporated the *Obstetric Anesthesia Policy* into this policy so that all guidelines related to anesthesia are in one place.)

Benefits application

Commercial

- ☑FCHP Direct Care/FCHP Select Care
- ☑Commonwealth Care
- ☑Companion Care
- ☑FCHP MassHealth
- ☑Major Medical
- ☑Fallon Preferred Care

Senior Plan

- ☑Fallon Senior Plan™
- ☑Fallon Senior Plan Preferred
- ☑Summit ElderCare®

Reimbursement

FCHP reimbursement consists of anesthesia base units plus anesthesia time units multiplied by a conversion factor. Anesthesia base units are derived from the American Society of Anesthesiologists (ASA).

Time units

- Anesthesia time begins when the anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room or in an equivalent area and ends when the anesthesiologist is no longer in personal attendance.

- FCHP uses duration of a time unit equal to 15 minutes with a 5-minute threshold. The threshold identifies the minimum number of minutes to be used as the threshold for calculating the entire time frame. For example, a procedure starts at 1:00 p.m. and ends at 1:20 p.m., 1 time unit would be added to the base unit.

Referral/notification/preauthorization requirements

No preauthorization is required for anesthesia services.

Billing/coding guidelines

Administration of anesthesia

- Services involving administration of anesthesia must be reported by the use of the anesthesia five-digit procedure code (00100 – 01999) plus the appropriate modifier code. Other CPT/HCPC codes must be used to report additional services. For anesthesia, show the elapsed time (minutes) in item 24g. Convert hours into minutes and enter the total minutes required for this procedure.

Anesthesia and discontinuous blocks of time

- When billing for discontinued anesthesia, you can bill for discontinuous blocks of time spent as long as there is continuous monitoring of the patient. Use modifier -53.

Epidural and spinal analgesia

- Epidural/spinal analgesia is used to manage post-operative pain or a medical diagnosis including administration of epidural/spinal analgesia as a single narcotic injection; insertion of an epidural spinal catheter for continuous post-operative pain management (fee includes the catheter insertion and all narcotic administration on that date). Do not bill separately with CPT codes 62310 and 62311.

Trigger point injections

- You can bill for trigger point injections per individual muscle; use 20552 for single or multiple trigger point(s) 1or 2 muscles regardless of number of injections into those muscle groups. Use 20553 for 3 or more muscles injected.

Services the day of, prior or post surgery

- Do not report ventilation management (94002; 94003) – if related to the **surgery anesthesia.**

- Do not report therapeutic services such as pulmonary function testing (PFT) related to general anesthesia service.

- Do not report CPT codes **62310-62319** on the day of surgery when the **epidural injection** (CPT 62311) is performed primarily for the surgical anesthetic and **not** for the post-operative narcotic.

Modifiers

Use the following modifiers when billing for anesthesia services:

- -AA – Physician personally performed
- -QK – Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals. Reimbursement will be at 50% of the allowable amount.
- -AD – Medical supervision by a physician: more than four concurrent anesthesia procedures. Reimbursement is based on three base units per procedure.
- -QY – Medical direction of one CRNA by an anesthesiologist. Reimbursement will be at 50% of the allowable amount.
- -QS – Monitored anesthesia care services. The -QS modifier must be submitted with modifiers -G8 or -G9.
- -QX – CRNA service with medical direction by a physician. Reimbursement will be at 50% of the allowable amount.
- -QZ – CRNA service without medical direction by a physician
- -QS – To indicate MAC services.

- FCHP does not provide separate or additional reimbursement for risk factor or physical status modifiers (-P1 – -P6).

The following procedures are reimbursed:

- Usual pre-operative and post-operative care.
- Anesthesia during the procedure.
- Anesthesia and discontinuous blocks of time.
- Epidural and spinal analgesia.
- FCHP caps time for vaginal delivery at 19 units; C-sections at 25 units.

The following procedures are **not** separately reimbursed by FCHP.

- Usual monitoring procedures that are part of and recorded on the anesthesia record. These procedures are an integral part of anesthesia services and are included in the anesthesia base unit value.
- Local anesthesia because it is considered part of the surgical procedure.
- Anesthesia services given by a physician who at the same time performs a surgical or obstetrical procedure because payment is included in the procedure.
- Conscious sedation (99143-99145, 99148-99150).
- Physician standby (99360).
- FCHP does not reimburse separately for the following CPT codes indicating qualifying circumstances:
  99100 - Anesthesia for patient of extreme age, under one year and over seventy.
  99116 - Anesthesia complicated by utilization of total body hypothermia.
  99135 - Anesthesia complicated by utilization of controlled hypotension.
  99140 - Anesthesia complicated by emergency conditions.

Place of service

This policy applies to services rendered in all settings.

Policy history

Origination date:	12/04/2002
Revision date(s):	10/12/2005, 01/18/2006, 01/03/2007, 03/10/08, 07/01/08 01/01/09 – Updated billing/coding guidelines section discussion of trigger point injections in response to 2009 CPT coding changes.
Connection date & details:	September 2009 – corrected CPT code for physician standby services to 99360.

This payment policy has been developed to provide information regarding general billing, coding and documentation guidelines for FCHP. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. FCHP reserves the right to apply this payment policy to all FCHP companies and subsidiaries.