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.

Benefits application

- ☑ FCHP Direct Care/FCHP Select Care
- ☑ Commonwealth Care
- ☑ Companion Care
- ☑ FCHP MassHealth
- ☑ Fallon Preferred Care PPO
- ☑ Fallon Senior Plan HMO
- ☑ Fallon Senior Plan PPO
- ☑ Summit ElderCare®
- ☑ NaviCare®

Reimbursement

FCHP reimbursement consists of anesthesia base units plus anesthesia time units multiplied by a conversion factor. For dates of service prior to January 1, 2012, anesthesia base units were derived from the American Society of Anesthesiologists (ASA). Effective for claims processed on or after January 1, 2012, FCHP will be applying the Medicare Anesthesia Base Unit values for anesthesia claims.

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.

The start and end time must be reported when submitting a paper claim to validate the number of units billed and the time must be reported in the patient's record.

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, including base; C-sections at 25 units, including base.

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

- Usual monitoring procedures. These procedures are an integral part of anesthesia services and are included in the anesthesia base unit value.
- Securing an airway, or intubation, including fiberoptic intubation, is integral to routine anesthesia administration and therefore is considered a part of the global anesthesia procedure.
- 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.

Certified Registered Nurse Anesthetists (CRNA) Services
FCHP will reimburse for the covered services provided by CRNAs that are within the scope of practice for the CRNA. Coverage is limited to those services a CRNA is legally authorized to perform in accordance with state statutes and regulations, and intuitional policy.

- *Medically directed CRNA services (QX)*
  The medically directed CRNA service is reimbursed at 50% of the rate of the anesthesiologist as per Medicare guidelines. A CRNA can only be paid 50% of one case, where an anesthesiologist can be paid 50% for each concurrently medically directed case up to four cases.
- *Non-medically directed CRNA services (QZ)*
  CRNA service without medical direction by a physician will be reimbursed in accordance with Medicare guidelines.

Referral/notification/prior authorization requirements

No prior authorization is required for anesthesia services with the exception of anesthesia assistance for upper and/or lower GI endoscopic procedures.

Beginning October 1, 2010, FCHP requires that all ordering physicians obtain prior authorization for the use of anesthesia with upper and lower GI endoscopic procedures. This requirement applies only to the use of an anesthesiologist or certified nurse anesthetist (CRNA) to provide a level of sedation deeper than conscious sedation. Anesthesiologists and CRNAs planning to bill CPT codes 00740 or 00810 should obtain a copy of the authorization number from the ordering physician before providing the service.

FCHP considers use of anesthesia services in association with GI endoscopy to be medically necessary under certain circumstances. FCHP considers anesthesia assistance medically necessary for plan members with one of the following risk factors for sedation related

complications that justifies the presence of an anesthesiologist during a GI endoscopic procedure:

- ASA Class III-IV i.e., severe systemic disease that limits physical activity
- Anticipated intolerance to regimens used for moderate sedation (i.e., benzodiazepines and/or narcotics), e.g., plan members with a history of long-term use/abuse of benzodiazepines, narcotics, alcohol, or neuropsychiatric medications
- Age under 18 years
- Uncooperative or extremely agitated plan members, such as plan members with senile dementia
- Pregnancy
- Previous problems with anesthesia or sedation
- Increased risk for airway obstruction or anatomic variant associated with difficult intubation
    - History of stridor or sleep apnea
    - Dysmorphic facial features, such as Pierre-Robin syndrome or Trisomy 21
    - Oral abnormalities, such as a small opening (<3 cm in an adult), edentulous, protruding incisors, high arched palate, macroglossia, tonsillar hypertrophy, or a nonvisible uvula
    - Neck abnormalities, such as obesity involving the neck and facial structures, short neck, limited neck extension, decreased hyoid-mental distance (<3 cm in an adult), neck mass, cervical spine disease or trauma, tracheal deviation, or advanced rheumatoid arthritis
- Plan members undergoing prolonged or complex endoscopic procedures requiring deep sedation, such as endoscopic retrograde cholangiopancreatography (ERCP) and endoscopic ultrasonography (EUS)

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

- Billing for discontinuous blocks of time is allowed 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.

Pre-operative consultation

- Submitting an Evaluation and Management (E&M) procedure code for a pre-operative consultation is not appropriate unless the surgery is cancelled subsequent to the pre-operative visit. In this case, reimbursement will be considered for an E&M service. *Payments are subject to post-payment audits and retraction of overpayments.*

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 pain management.

Gastroenterology services

- Anesthesia assistance for upper GI endoscopy (CPT code 00740) and/or lower GI endoscopy (CPT code 00810) with prior authorization by FCHP

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.
- -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).

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 01/01/2009 – Updated billing/coding guidelines section discussion of trigger point injections in response to 2009 CPT coding changes. 11/1/2009 - corrected CPT code for physician standby services to 99360. 11/1/2010 – Updated to reflect prior authorization requirement for anesthesia assistance for upper and/or lower GI endoscopic procedures. 07/01/2011 – Added language discussing CRNAs and clarified discussion of OB caps.
Connection date & details:	November 2011 – Updated policy to reflect that FCHP will be applying the Medicare Anesthesia Base Unit values for anesthesia claims beginning January 1, 2012 and that FCHP does not reimburse separately for fiberoptic intubation.

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. FCHP routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.