

Anesthesia Payment Policy

Policy

The Plan 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 pre-operative and post-operative 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.

Reimbursement

Plan 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, the Plan 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.
- The Plan uses a duration of 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.
- The Plan caps time for vaginal delivery at 19 units, including base; C-sections at 25 units, including base. The cap is inclusive of insertion to delivery and the conclusion of related services. When postpartum procedures under anesthesia (e.g., manual extraction, laceration repair) extend the duration of anesthesia care beyond the cap, services will be reviewed for additional reimbursement.

The following procedures are not separately reimbursed by the Plan:

- 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
- Physician standby.
- The Plan 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:

The Plan 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 institutional 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.

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 with preventive GI screenings:

- In order to be recognized as preventive, claims for the use of anesthesia (00812 with preventive GI endoscopic procedures must indicate a screening ICD code in the primary diagnosis position on the claim.

The following codes will be recognized as preventive:

ICD-10 code	Description
Z12.10	Encounter for screening for malignant neoplasm of intestinal tract, unspecified
Z12.11	Encounter for screening for malignant neoplasm of colon
Z12.12	Encounter for screening for malignant neoplasm of rectum
Z12.13	Encounter for screening for malignant neoplasm of small intestine

Anesthesia and discontinuous blocks of time:

- Billing for discontinuous blocks of time is allowed as long as there is continuous monitoring of the patient during the discontinuous block of time.

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).

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) 1 or 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 62320-62327 on the day of surgery when the epidural injection is performed primarily for the surgical anesthetic and not for the post-operative pain management.

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.
- 22 – Increased Procedural Service.
- 59– Distinct Procedural Service.
- The Plan 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
Previous 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. 01/01/2012 - Updated policy to reflect that CH will be applying the Medicare Anesthesia Base Unit values for anesthesia claims beginning January 1, 2012 and that FH does not reimburse separately for fiberoptic intubation. 05/01/2013 - Updated policy to include that claims for the use of anesthesia (00810) with preventive GI endoscopic procedures that have been prior authorized must indicate a

screening ICD-9 code in the primary diagnosis position on the claim.
09/01/2014 - Added ICD-10 codes under preventive GI screenings and moved to Fallon Health logo and template.
05/01/2015 – Removed prior authorization requirement language from anesthesia assistance for upper and/or lower GI endoscopic procedures.
01/01/2016 - Moved to new Plan template. Updated billing/coding section and added modifiers 22 and 59.
03/01/2016 - Updated reimbursement and billing/coding sections.
11/01/2016 - Added clarifying language regarding time units.
March 2017 – Replaced termed codes.
April 2018 – Annual Review, no updates.
April 2019 - Annual Review, no updates.
April 2020 – Annual Review, no updates.

Connection date & details:

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding and documentation guidelines for the Plan. 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. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan 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.