REIMBURSEMENT GUIDELINES – Anesthesia

Product Applicability

☐ All Plan* Products

Boston Medical Center HealthNet Plan*
  ☑ MassHealth
  ☑ Qualified Health Plans/ConnectorCare/Employer Choice Direct
  ☑ Commonwealth Care
  ☑ Commonwealth Choice/Employer Choice

Well Sense Health Plan*
  ☐ New Hampshire Medicaid
  ☐ _______________________

Effective Date: 7/5/2006
Policy Number: 4.103

This policy is intended to serve as a general guide for reimbursement. Please refer to the MassHealth Member Handbook, BMC HealthNet Plan Qualified Health Plans, including ConnectorCare, the Commonwealth Care or Commercial Evidence of Coverage (EOC), Schedule of Benefits (SOB) and your provider contract for specific terms of coverage and reimbursement. Unless otherwise specified in writing, reimbursement will be made at the lesser of the billed charges, or the contractual schedule of payments. Use of this policy does not guarantee payment.

Prior-authorization

Please refer to the Plan’s Prior Authorization Requirements Matrix at www.bmchp.org.

Policy Statement
The Plan reimburses covered services based on the provider’s contractual rates with the Plan and the terms of reimbursement identified within this policy.

Reimbursement is based on member benefits and eligibility, medical necessity review, where applicable, coordination of benefits, adherence to Plan policies, clinical coding criteria, and the BMC HealthNet Plan agreement with the rendering or dispensing provider. Plan policies may be amended at BMC HealthNet Plan’s discretion. All Plan policies are developed in accordance with state, federal and accrediting organization guidelines and requirements, including NCQA.

Origination Date: 07/05/2006

BMC HealthNet Plan – Anesthesia
Anesthesia Reimbursement

Medical/Surgical Procedures
Medical or surgical procedures performed by an anesthesia provider will be reimbursed at the lesser of the provider’s billed charges or the BMC HealthNet Plan physician fee schedule, subject to the clinical editing criteria established in this and other policies.

Add-On Codes
When an add-on code is used with an anesthesia code, reimbursement will be calculated for both the primary and add-on procedure codes, in addition to the total time for the complete procedure.

Personally Performed
Personally performed anesthesia services are paid using the standard rate calculation for anesthesia services, as outlined in the provider contract.

Medically Directed Anesthesia Services
Where a single anesthesia procedure involves both a physician medical direction service and the service of the medically directed certified registered nurse anesthetist (CRNA), the payment amount for each separate service may be no greater than 50 percent of the allowance had the service been furnished by the anesthesiologist alone.

Reimbursement for CRNA Services
The Plan will utilize the same base unit and conversion factor values when calculating CRNA payment rates.

- Modifier QX must be used by the CRNA to indicate services that were medically directed by a physician – reimbursement will be 50% of the base procedure code reimbursement rate
- Modifier QZ must be used by the CRNA to indicate services that were without medical direction of a physician – reimbursement will be 100% of the base procedure code reimbursement rate

Anesthesia Billing Guidelines
The anesthesia procedure codes (00100 – 01999) listed in the current year’s CPT manual, are the only anesthesia codes eligible for reimbursement. Use of a surgical code with an anesthesia modifier is not an acceptable billing method. Failure to use appropriate anesthesia coding may result in denial of the procedure or service.
Modifiers
BMC HealthNet Plan accepts anesthesia modifiers when billed with appropriate CPT codes that identify an anesthesia service. The following modifiers may be used to report anesthesia services.

- AA – Anesthesia performed personally by an anesthesiologist
- AD – Medically supervised by a physician for more than four concurrent procedures
- QK – Medically directed by a physician: two, three, or four concurrent procedures
- QX – CRNA with medical direction by a physician
- QY – Medical direction of one CRNA by an anesthesiologist
- QZ – CRNA without medical direction by a physician
- QS – Monitored anesthesia care
- G8 – Monitored anesthesia care for deep complex, complicated, or markedly invasive surgical procedure
- G9 – Monitored anesthesia care for patient who has a history of severe cardiopulmonary disease
- 53 – Discontinued procedure will be reimbursed at 25% of the base reimbursement rate for that specific code

Physical status modifiers are not eligible for additional reimbursement beyond the base unit value assigned to the procedure code.

Specific Terms of Reimbursement for Anesthesia Care
The following specific terms of payment apply to anesthesia services rendered to a Plan member.

Pain Management
BMC HealthNet Plan does not reimburse for acute post-surgical pain management services, unless such services are performed by a pain management specialist due to the severity of the member’s condition.

Time spent by an anesthesiologist administering a nerve block is included in the total anesthesia time and is not ordinarily eligible for separate reimbursement. Additional reimbursement is only warranted when identified as a distinct procedure by the use of modifier 59.

The following points are based on the CMS (Centers for Medicare & Medicaid Services) NCCI (National Correct Coding Initiative) policy manual guidelines:

- Postoperative pain management should not be reported by the anesthesiologist unless a separate and medically necessary service that cannot be rendered by the surgeon is required. The rationale being that pain management is generally bundled in the global
surgical payment. It will be reimbursed as a separate procedure, in conjunction with anesthesia, when supported by documentation of the surgeon’s written order requesting postoperative pain management be performed by the anesthesiologist.

Daily Management for Postoperative Management
Daily hospital management of epidural or subarachnoid drug (01996) are eligible for reimbursement for one (1) units per day for up to three (3) days following the surgery, beginning the day after surgery.

Charges for four (4) or more days of this service will be reviewed before a payment decision is made.

Monitored Anesthesia Care
Monitored anesthesia care (MAC) (HCPCS Level II Modifiers G8, G9) is eligible for reimbursement as long as there is no more than one provider billing for anesthesia. In order for MAC to be covered, there must be medically necessary anesthesia care performed on the same date of service.

Nerve Block Administration
Injections/blocks administered as a therapeutic agent in the treatment of a nonsurgical condition should continue to be reported under the appropriate injection/block codes (62273, 62280-62282, 62284, 62310, 62311, 62318, 62319 and 64400-64530).

Patient Controlled Analgesia (PCA)
When PCA is initiated, BMC HealthNet Plan will reimburse for the initial catheter insertion, if not performed as a part of a surgical anesthesia event. Time units and anesthesia base units are not applicable for this service. BMC HealthNet Plan will provide payment for postoperative PCA evaluation and management services when billed with an appropriate Evaluation and Management code, with appropriate supporting documentation.

Epidurals
The following policies apply to the insertion and management of epidurals. Failure to follow these policies will result in claim denial.

Epidural Insertion
BMC HealthNet Plan will reimburse providers for an epidural insertion (62318 or 62319) only when it is for therapeutic, non-surgical, pain management, or when it is allowed according to other terms within this policy.

BMC HealthNet Plan will reimburse providers for the injection of narcotics (62310 or 62311) if the administration occurs on a day following the surgical procedure.
Otherwise it is considered inclusive to the insertion procedure.

Epidural Narcotics Administration and Daily Epidural Management
BMC HealthNet Plan will reimburse providers for the injection of narcotics (62310 or 62311, ASA code 01966) if the services occurs on a day following the catheter insertion.

Electroconvulsive Therapy
Services for electroconvulsive therapy are reimbursable as a separate procedure as long as the therapy and procedure are not both performed by a psychiatrist. When billing as a separate procedure, code 00104 should be used.

Bundled Anesthesiology Services
BMC HealthNet Plan partially bases clinical coding edits on CMS NCCI. These guidelines identify which services are included in the allowance for the primary procedure. In addition to any of the CCI edits, the following reimbursement rules apply to anesthesia payments.

Services Included in other Fees
The following services are considered inclusive to the fees paid to the provider for other anesthesia or surgical care, unless stated otherwise in this policy.

- Field avoidance – this is included in the allowance for the anesthesia procedure
- Local anesthesia – this is considered inclusive to the fees paid for the surgical procedure
- Separate payment is not allowed for any anesthesia services performed by the physician who also performs the medical or surgical procedure. Payment for administering anesthesia is included in the fees paid to the physician for the primary surgical procedure
- Separate payment is not allowed for a psychiatrist’s performance of an anesthesia service associated with the electroconvulsive therapy if the psychiatrist performs both procedures
- Pre-anesthetic examination of a patient and pre- or post-operative visits since these are included in the payment for anesthesia administration
- Monitoring functions, except for those services identified in this policy
- Postoperative pain consultations when performed on the same date of service as the surgical procedure

Anesthesia for Obstetrical Services
BMC HealthNet Plan limits the total billable time associated with specific obstetrical procedures, as outlined below:

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Origination Date: 07/05/2006

BMC HealthNet Plan – Anesthesia

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<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Maximum Time Allowed</th>
</tr>
</thead>
<tbody>
<tr>
<td>01960</td>
<td>Anesthesia for vaginal delivery only</td>
<td>60 minutes</td>
</tr>
<tr>
<td>01961</td>
<td>Anesthesia for cesarean delivery only</td>
<td>120 minutes</td>
</tr>
<tr>
<td>01962</td>
<td>Anesthesia for urgent hysterectomy following delivery</td>
<td>120 minutes</td>
</tr>
<tr>
<td>01963</td>
<td>Anesthesia for cesarean hysterectomy, without any labor analgesia/anesthesia care</td>
<td>240 minutes</td>
</tr>
<tr>
<td>01967</td>
<td>Neuraxial labor analgesia/anesthesia for planned vaginal delivery</td>
<td>300 minutes</td>
</tr>
<tr>
<td>01968</td>
<td>Anesthesia for cesarean delivery, following neuraxial labor analgesia/anesthesia</td>
<td>360 minutes</td>
</tr>
<tr>
<td>01969</td>
<td>Anesthesia for cesarean hysterectomy, following neuraxial labor analgesia/anesthesia</td>
<td>480 minutes</td>
</tr>
</tbody>
</table>

**Non-Reimbursable Anesthesia Services**

The following services are not payable when rendered to a BMC HealthNet Plan member. Submitting a claim with any of these codes will result in a denial.

- Anesthesia complicated by utilization of total body hypothermia (99116)
- Anesthesia complicated by utilization of controlled hypotension (99135)
- Anesthesia for patient of extreme age, under one year or over seventy (99100)
- Anesthesia complicated by emergency conditions (99140)
- Conscious sedation (99143-99150)
- Standby anesthesia is not covered since this service is not direct patient care Qualifying circumstance codes (99100 – 99140)
- Physical status modifiers are not recognized by the Plan and will not be used during claim processing activities (P1-P6)
- Services billed with modifier 23, Unusual Anesthesia
- Services billed with modifier 47, Anesthesia by Surgeon
- Any anesthesia services rendered to support a non-covered service

**References**

**Legal and Regulatory References**

- Contract between The Office of Health and Human Services (EOHHS), and Boston Medical Center HealthNet Plan MassHealth
- Evidence of Coverage, Commonwealth Care, Form No. BMCHP-CC-8
- Evidence of Coverage, CommChoice, Form No. BMCHP CChoice-1

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Other References

- Healthcare Common Procedure Coding System (HCPCS), Level II Codes
- International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)

In addition to the above regulations, any bulletin issued to amend or otherwise change the above regulations are herein incorporated as references.

Policy History and Approval Dates

Review Dates/Revisions:
- 02/14/2006 – Original approval
- 05/06/2006 – Reformatting and reorganization
- 07/05/2006 – Modification to CRNA reimbursement and medical supervision reimbursement terms. Eliminated reference to 85% of physician fees, and added section on 50%/50% reimbursement to supervising MD and CRNA services. Also modified approving entity to Benefit Review Committee.
- 12/06/2006 – Updated to accommodate the implementation of Commonwealth Care
- 12/03/2007 – Updated Nerve Block section, formatting, and coding for 2008 code release.
- 09/30/2008 – Updated to clarify coverage of services associated with Nerve Block administration
- 10/12/2011 – Updated coding
- 12/04/2013 – Updated template, product applicability section, and references for BMC HealthNet Plan Qualified Health Plans, including ConnectorCare

Approval Dates

Original Effective Date: 02/14/2006
Original Internal Approval Date: 12/06/2006
Original Regulatory Approval Date: N/A