Reimbursement Policy

Anesthesia

Policy Number: 4.103
Version Number: 9
Version Effective Date: 01/01/2017

<table>
<thead>
<tr>
<th>Product Applicability</th>
<th>All Plan Products</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Well Sense Health Plan</td>
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<tr>
<td>□ New Hampshire Medicaid</td>
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<tr>
<td>□ NH Health Protection Program</td>
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<td>□ Boston Medical Center HealthNet Plan</td>
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<td>☑ MassHealth</td>
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<tr>
<td>☑ Qualified Health Plans/ConnectorCare/Employer Choice Direct</td>
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<tr>
<td>☑ Senior Care Options</td>
<td></td>
</tr>
</tbody>
</table>

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

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

Prior-Authorization

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

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Provider 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 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**
The 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**
The 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, XE, XP, XS, or XU.

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 surgeons 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.
**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, 62320-62327 and 64400-64530).

**Patient Controlled Analgesia (PCA)**
When PCA is initiated, the 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. The 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:**
  The Plan will reimburse providers for an epidural insertion only when it is for therapeutic, non-surgical, pain management, or when it is allowed according to other terms within this policy.
  The Plan will reimburse providers for the injection of narcotics 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:**
  The Plan will reimburse providers for the injection of narcotics if the services occur 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**
The 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:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
<th>Maximum Time Allowed</th>
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<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>
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<tr>
<td>01967</td>
<td>Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)</td>
<td>300 minutes</td>
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<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>
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</tbody>
</table>

Service Limitations
Non-Reimbursable Anesthesia Services
The following services are not payable when rendered to a 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 (99151-99157, G0500)
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- Standby anesthesia is not reimbursed 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

Policy History

<table>
<thead>
<tr>
<th>Original Approval Date</th>
<th>Original Effective Date</th>
<th>Policy Owner</th>
<th>Approved by</th>
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<td>12/06/2006</td>
<td>02/14/2006</td>
<td>Payment Policy</td>
<td>Payment Policy Committee</td>
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Policy Revisions History

<table>
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<th>Review Date</th>
<th>Summary of Revisions</th>
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<tr>
<td>05/06/2006</td>
<td>Reformatting and reorganization</td>
<td>05/06/2006</td>
<td>Payment Policy Committee</td>
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<td>07/05/2006</td>
<td>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.</td>
<td>07/05/2006</td>
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<tr>
<td>12/06/2006</td>
<td>Updated to accommodate the implementation of Commonwealth Care</td>
<td>12/06/2006</td>
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<tr>
<td>12/03/2007</td>
<td>Updated Nerve Block section, formatting, and coding for 2008 code release.</td>
<td>12/03/2007</td>
<td>Payment Policy Committee</td>
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<tr>
<td>09/30/2008</td>
<td>Updated to clarify coverage of services associated with Nerve Block administration</td>
<td>09/30/2008</td>
<td>Payment Policy Committee</td>
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<td>10/12/2011</td>
<td>Updated coding</td>
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**Policy Revisions History**

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<tr>
<td>12/04/2013</td>
<td>Updated template, product applicability section, and references for BMC HealthNet Plan Qualified Health Plans, including ConnectorCare</td>
<td>12/04/2013</td>
<td>Payment Policy Committee</td>
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<tr>
<td>12/12/2016</td>
<td>New template, added X{EPSU} modifiers, updated coding</td>
<td>01/01/2017</td>
<td>Payment Policy Committee</td>
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**Other Applicable Policies**

- General Billing and Coding Guidelines, 4.31
- General Clinical Editing and Payment Accuracy Review Guidelines, 4.108
- Physician and Non-Physician Practitioner Services, 4.608

**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
- Form of Contract between the Commonwealth Health Insurance Connector Authority and Boston Medical Center HealthNet Plan
- DHCFP Regulation 114.3 CMR 16.00 – Surgery and Anesthesia
- MassHealth Regulation 130 CMR 433, Subchapters 1 through 6
- BMC HealthNet Plan Qualified Health Plans, including ConnectorCare Evidence of Coverage

**Disclaimer Information**

This Policy provides information about the Plan’s reimbursement/claims adjudication processing guidelines. The use of this Policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement. Member cost-sharing (deductibles, coinsurance and copayments) may apply – depending on the member’s benefit plan. Unless otherwise specified in writing, reimbursement will be made at the lesser of billed charges or the contractual rate of payment. Plan policies may be amended from time to time, at Plan’s discretion. Plan policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization guidelines (including NCQA). The Plan reserves the right to conduct Provider audits to ensure compliance with this Policy. If an audit determines that the Provider did not comply with this Policy, the Plan will expect the Provider to refund all payments related to non-compliance. For more information about the Plan’s audit policies, refer to the Provider Manual.

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