Payment Policy: Anesthesia Reimbursement (Commercial & Medicare)

POLICY NUMBER	EFFECTIVE DATE	APPROVED BY
R20190016	10/01/2019	RPC (Reimbursement Policy Committee)

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY:

ConnectiCare has policies in place that reflect billing or claims payment processes unique to our health plans. Current billing and claims payment policies apply to all our products, unless otherwise noted. ConnectiCare will inform you of new policies or changes in policies through updates to the Provider Manual and/or provider news. The information presented in this policy is accurate and current as of the date of this publication.

The information provided in ConnectiCare's policies is intended to serve only as a general reference resource for services described and is not intended to address every aspect of a reimbursement situation. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, physician or other provider contracts, the member's benefit coverage documents and/or other reimbursement, medical or drug policies. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by ConnectiCare due to programming or other constraints; however, ConnectiCare strives to minimize these variations.

ConnectiCare follows coding edits that are based on industry sources, including, but not limited to; CPT® guidelines from the American Medical Association, specialty organizations, and CMS including NCCI and MUE. In coding scenarios where there appears to be conflicts between sources, we will apply the edits we determine are appropriate. ConnectiCare uses industry-standard claims editing software products when making decisions about appropriate claim editing practices. Upon request, we will provide an explanation of how ConnectiCare handles specific coding issues. If appropriate coding/billing guidelines or current reimbursement policies are not followed, ConnectiCare may deny the claim and/or recoup claim payment.

Overview

ConnectiCare, Inc.'s Anesthesia policy is developed in part using the Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) Policy Manual, CMS NCCI edits and the CMS National Physician Fee Schedule, American Society of Anesthesiologists guidelines, and its own medical policies regarding the coding of claims.

These services may include, but are not limited to, general or regional anesthesia, monitored anesthesia care, or other services to provide the patient the medical care deemed optimal. All services described in this policy may be subject to additional ConnectiCare reimbursement policies.

This reimbursement policy applies to services reported on a CMS 1500 Health Insurance Claim Form or Electronic (EDI) HIPAA 5010 complaint 837P format claim submission. Services involving the administration of anesthesia are to be submitted with a CPT® code in the range 00100-01999 plus applicable modifier code. These codes are reimbursed as time-based using the Standard Anesthesia Formula.

Billing Instructions (eg. Preauthorization)

- Submit claims using the provider NPI for the individual provider. Apply the appropriate anesthesia modifier in the first modifier field.
- Anesthesia CPT® codes should be billed in minutes representing the duration of the service. ConnectiCare will divide the number of minutes billed by 15 (the anesthesia unit equivalent) and add that number to the assigned Basic Unit Value to determine total anesthesia units.
- Modifiers P3, P4 or P5 may be billed with additional minutes added to the anesthesia code to represent the corresponding units for these modifiers. Place these in the second modifier field.
- ConnectiCare also requires that the "start" and "end" times be provided in the Notes section of an electronic claim, or box 24A on a paper claim.
- CPT® codes for non-anesthesia services, including Qualifying Circumstances, should be billed as one unit; no minutes should be billed for these codes.
- Anesthesia CPT® codes will be reimbursed based on the applicable fee schedule for anesthesia units. Payment will be reduced when a CRNA is supervised. Refer to the modifier information below.
- When more than one anesthesia service is billed for the same date of service, base units will be reimbursed only for the procedure with the highest base unit value. Lesser procedures will be reimbursed for time only.

Reimbursement Formula and Modifiers

Reimbursement Formula

Base Value: Each CPT® anesthesia code is assigned a Base Value. ConnectiCare follows CMS Anesthesia base units by CPT® code.

Time Reporting: Consistent with CMS guidelines, ConnectiCare requires actual anesthesia time in minutes reported on the claim. Please refer to https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

Standard Anesthesia Calculation:

(Base Units + Physical Status + Time) x Anesthesia Conversion Factor = Allowance

Anesthesia Modifiers

Modifier Code	Modifier Description	Reimbursement
AA	Anesthesia services performed personally by the anesthesiologist.	100% of the allowance
AD	Medical supervision by a physician; more than four concurrent anesthesia procedures.	50% of the allowance

Modifier Code	Modifier Description	Reimbursement
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals.	50% of the allowance
QX	Qualified non-physician anesthetist with medical direction by a physician	50% of the allowance
QY	Medical direction of one qualified non-physician anesthetist by an anesthesiologist.	50% of the allowance
QZ	CRNA service; without medical direction by a physician.	100% of the allowance

Informational Only Modifiers	
When Reporting modifiers 23, 47, GC, G8, G9 or QS; no additional reimbursement is allowed above the usual fee for that service.	
GC	This service has been performed in part by a resident under the direction of a teaching physician.
G8	Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure.
G9	Monitored anesthesia care (MAC) for patient who has a history of severe cardiopulmonary condition.
QS	Monitored anesthesiology care services (can be billed by a qualified non-physician anesthetist or a physician).
47	Anesthesia by Surgeon
23	Unusual Anesthesia

Physical Status Modifiers*		
Physical status modifiers identify levels of complexity of the anesthesia services. The P-modifiers are reported in conjunction with anesthesia CPT® code (00100-01999) when appropriate.		
P1	A physical status modifier for a normal healthy patient.	0 units
P2	A physical status modifier for a patient with mild systemic disease.	0 units

Physical Status Modifiers*		
P3	A physical status modifier for a patient with severe systemic disease.	1 unit
P4	A physical status modifier for a patient with severe systemic disease that is a constant threat to life.	2 units
P5	A physical status modifier for a moribund patient who is not expected to survive without the operation.	3 units
P6	A physical status modifier for a declared brain-dead patient whose organs are being removed for donor purposes.	0 units

CMS does not recognize or issue additional reimbursement for Physical Status (P) modifiers.

Qualifying Circumstances for Anesthesia

Consistent with CMS, ConnectiCare does not allow separate reimbursement outside of the primary anesthesia code. These codes are assigned a status indicator of "B" (bundled code) on the CMS Physician Fee schedule and are not eligible for separate reimbursement under Medicare guidelines. As per CMS, the value for the qualifying circumstances has already been included in the RVUs for the primary anesthesia procedure codes. Payment for these services is always included in payment for other services not specified. There are no RVUs or payment amount for these codes and separate payment is not made.

The following Qualifying Circumstances Codes are not reimbursable:	
CPT® Code	**Code Description**
99100	Anesthesia for patient of extreme age, younger than 1 year and older than 70 (List separately in addition to code for primary anesthesia procedure)
99116	Anesthesia complicated by utilization of total body hypothermia (List separately in addition to code for primary anesthesia procedure).
99135	Anesthesia complicated by utilization of controlled hypotension (List separately in addition to code for primary anesthesia procedure).
99140	Anesthesia complicated by emergency conditions (specify) (List separately in addition to code for primary anesthesia procedure)

Multiple or Duplicate Anesthesia Services

Multiple Anesthesia Services:
According to the ASA, when multiple surgical procedures are performed during a single anesthesia administration, only the single anesthesia code with the highest Base Unit Value is reported. The time reported is the combined total for all procedures performed on the same patient on the same date of service by the same or different physician or other qualified health care professional. Add-on anesthesia codes (01953, 01968 and 01969) are exceptions to this and are addressed in the Anesthesia Services section and Obstetric Anesthesia Services section of this policy.
ConnectiCare, Inc aligns with these ASA coding guidelines. Specific reimbursement percentages are based on the anesthesia modifier(s) reported.

Duplicate Anesthesia Services:
When duplicate (same) anesthesia codes are reported by the same or different physician or other qualified health care professional for the same patient on the same date of service, ConnectiCare, Inc will only reimburse the first submission of that code. However, anesthesia administration services can be rendered simultaneously by an MD and a CRNA during the same operative session, each receiving 50% of the Allowed Amount (as indicated in the Modifier Table above) by reporting modifiers QK or QY and QX.
In the event an anesthesia administration service is provided during a different operative session on the same day as a previous operative session, ConnectiCare, Inc will reimburse one additional anesthesia administration appended with modifier 59, 76, 77, 78, 79 or XE. As with the initial anesthesia administration, only the single anesthesia code with the highest Base Unit Value should be reported.

Anesthesia and Procedural Bundled Services

ConnectiCare, Inc. sources anesthesia edits to methodologies used and recognized by third party authorities (referenced in the Overview section) when considering procedural or pain management services that are an integral part of anesthesia services, and anesthesia services that are an integral part of procedural services. Those methodologies can be Definitive or Interpretive. A Definitive source is one that is based on very specific instructions from the given source. An Interpreted source is one that is based on an interpretation of instructions from the identified source.
Procedural/pain management services or anesthesia services that are identified as bundled (integral) are not separately reimbursable when performed by the Same Individual Physician or Other Qualified Health Care Professional on the same date of service. The Same Individual Physician or Other Qualified Health Care Professional is defined as the same individual rendering health care services reporting the same Federal Tax Identification number.

Procedural or Pain Management Services Bundled in Anesthesia Services:
• Services in the CMS National Physician Fee Schedule that have a status indicator of B (Bundled code); Status N; or T (Injections);
• Nerve Block codes billed in conjunction with anesthesia services when modifier 59, XE or XU is not appended to the nerve block code

Anesthesia Services Bundled in Procedural Services:
According to the NCCI Policy Manual, Chapter 1, CMS does not allow separate payment for anesthesia services performed by the physician who also furnishes the medical or surgical procedure, excluding Moderate Sedation. In these situations, the allowance for the anesthesia service is included in the payment for the medical or surgical procedure. In addition, AMA states "if a physician personally performs the regional or general anesthesia for a surgical procedure that he or she also performs, modifier 47 would be appended to the surgical code, and no codes from the anesthesia section would be used."

ConnectiCare will not separately reimburse an anesthesia service when reported with a medical or surgical procedure (where the anesthesia service is the direct or alternate crosswalk code for the medical or surgical procedure) submitted by the Same Individual Physician or Other Qualified Health Care Professional for the same patient on the same date of service.

Preoperative/Postoperative Visits:
Consistent with CMS, ConnectiCare will not separately reimburse an E/M service (excluding critical care CPT® codes 99291-99292) when reported by the Same Specialty Physician or Other Qualified Health Care Professional on the same date of service as an anesthesia service. Critical care CPT® codes 99291-99292 are not considered included in an anesthesia service and will be separately reimbursed.

The Same Specialty Physician or Other Qualified Health Care Professional is defined as physicians and/or other qualified health care professionals of the same group and same specialty reporting the same Federal Tax Identification number.

Daily Hospital Management:
Daily hospital management of epidural or subarachnoid drug administration (CPT® code 01996) in a CMS place of service 19 (off campus outpatient hospital), 21 (inpatient hospital), 22 (on campus outpatient hospital) or 25 (birthing center) is a separately reimbursable service once per date of service excluding the day of insertion. CPT® code 01996 is considered included in the pain management procedure if submitted on the same date of service by the Same Individual Physician or Other Qualified Health Care Professional.

If the anesthesiologist continues with the patient's care after discharge, the appropriate Evaluation and Management code should be used.

Obstetric Anesthesia Services

Consistent with the ASA guide for appropriate reporting neuraxial analgesia/anesthesia should be reported only for face to face time with the patient. The documentation must report total minutes and start and stop times for each time the face to face service is rendered. A notation must be made in the medical record, signed by the anesthesiologist or CRNA, which confirms that they visited the laboring patient during each hour of labor (a short progress note is acceptable for this notation).

- Insertion and Management: When a provider inserts the epidural catheter and participates in on-going management and monitoring of the patient's epidural analgesia, the anesthesia code 01967 (for vaginal delivery) or 01967 and 01968 (for cesarean delivery)

should be billed for the complete service, using the appropriate anesthesia modifier, with anesthesia time units for actual face-to-face time. It would not be appropriate to bill 62311 or 62319 for the insertion of the catheter, in addition to the epidural management code.

- Management Only: In many cases, a physician will insert the epidural catheter, but a CRNA is responsible for the on-going management and monitoring of the patient's epidural analgesia. When this is the case, the CRNA should submit the anesthesia code (e.g., 01967) using the appropriate anesthesia modifier, with anesthesia time units for actual face-to-face time. The anesthesiologist should submit the insertion only service code, 62319.

Neuraxial Labor Analgesia Reimbursement Calculations:
Consistent with a method described in the ASA RVG® ConnectiCare will reimburse neuraxial labor analgesia (CPT® code 01967) based on Base Unit Value plus Time Units subject to a cap of 435 minutes. Modifying Units for physical status modifiers and qualifying circumstance codes will be considered in addition to the Base Unit Value for labor or delivery anesthesia services in accordance with the Standard Anesthesia Formula. Any claims over the cap will need medical records to support units billed.

Obstetric Add-On Codes:
ConnectiCare, Inc. will consider for reimbursement, add-on CPT® codes 01968 and 01969 (c-section anesthesia) when billed with the primary CPT® code 01967 (by the same or different individual physician or other qualified healthcare professional) for the same member. According to the ASA Crosswalk® time for add-on code 01968 or 01969 is reported separately as a surgical anesthesia service and is not added to the time reported for the labor anesthesia service.

Revision history

DATE	REVISION
09/2019	• Reformatted and reorganized policy, transferred content to new template with new Reimbursement Policy Number