INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Anesthesia Services

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Revision History

Version	Date	Reason for Revisions	Completed By
1.0	Policies and procedures as of October 1, 2015 Published: February 25, 2016	New document	FSSA and HPE
1.1	Policies and procedures as of April 1, 2016 Published: July 28, 2016	Scheduled update	FSSA and HPE
1.2	Policies and procedures as of April 1, 2016 (*Core*MMIS updates as of February 13, 2017) Published: February 13, 2017	*Core*MMIS update	FSSA and HPE
2.0	Policies and procedures as of July 1, 2017 Published: December 12, 2017	Scheduled update	FSSA and DXC
3.0	Policies and procedures as of September 1, 2018 Published: February 21, 2019	Scheduled update: • Edited and reorganized text as needed for clarity • Updated the note box at the beginning of the module with standard verbiage • Updated links to the new IHCP website • In the *Introduction* section, added information about the scope of anesthesia services and added that PA is not required • Updated billing information in the *Anesthesia Procedure Codes and Modifiers* section • Added a definition for anesthetist in the *Medical Direction Requirements* section • Added introductory text to the *Regional Anesthesia* section	FSSA and DXC

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Note:	*For updates to coding, coverage, and benefit information, see IHCP Banner Pages and Bulletins at in.gov/medicaid/providers.* *The information in this module applies to services provided under the fee-for-service delivery system. Within the managed care delivery system, individual managed care entities (MCEs) establish their own coverage criteria, prior authorization requirements, billing procedures, and reimbursement methodologies. For services covered under the managed care delivery system, providers must contact the Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise member's MCE or refer to the MCE provider manual for specific policies and procedures. MCE contact information is included in the IHCP Quick Reference Guide at in.gov/medicaid/providers.*

Introduction

Anesthesia services may include, but are not limited to, general anesthesia, regional anesthesia, supplementation of local anesthesia, or other supportive services to give a patient the anesthesia care deemed optimal by the anesthesiologist to reduce or mitigate pain during a procedure. The services include the usual preoperative and postoperative visits, anesthesia care during the procedure, the administration of fluids and/or blood, and the usual monitoring services (such as electrocardiogram [ECG], temperature, blood pressure, oximetry, capnography, and mass spectrometry). Other monitoring services (such as intra-arterial, central venous, and Swan-Ganz) are not included.

The following types of general and regional anesthesia are eligible for separate reimbursement under the Indiana Health Coverage Programs (IHCP), when provided by a physician other than the operating surgeon:

- Field block
- Inhalation
- Intravenous
- Neuraxial (spinal or epidural)
- Regional or selective nerve block

General or regional anesthesia administered by the same provider performing a surgical or obstetrical delivery procedure is not separately reimbursable, because it is included in the surgical delivery fee.

Prior authorization is not required for anesthesia services.

Anesthesia Procedure Codes and Modifiers

The Administrative Simplification Requirements of the *Health Insurance Portability and Accountability Act* (HIPAA) mandate that covered entities adopt the standards for anesthesia Current Procedural Terminology (CPT®[1]) codes. To bill for anesthesia services, providers use anesthesia CPT codes 00100 through 01999 and a physical status modifier that corresponds to the status of the member undergoing the surgical procedure. Modifier 50 – *Bilateral procedure* should not be used in conjunction with anesthesia procedure codes.

[1] *CPT copyright 2018 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.*

Certain nonanesthesia CPT codes (CPT codes *other than* 00100–01999) must include an AA modifier to denote that they apply to anesthesia services. These anesthesia services must be billed as a separate line item of the claim form and are reimbursed on a maximum fee basis. For a list of anesthesia-related procedure codes that require the AA modifier, see the *Anesthesia Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers.

Providers may also use the AA modifier with anesthesia codes 00100–01999 and add-on code 99140 – *Anesthesia complicated by emergency conditions (specify)*, as appropriate. Note that use of the AA modifier is not required for these codes; it is considered informational and does not affect payment.

For general information about billing and coding, see the *Claim Submission and Processing* module.

Reimbursement Methodology for Anesthesia Services

IHCP pricing calculation for anesthesia CPT codes 00100 through 01999 is as follows:

Base Units
\+ **Time Units**
\+ **Additional Units for age (if applicable)**
\+ **Additional Unit for emergency or other qualifying circumstances (if applicable)**
\+ **Additional Units for physical status modifiers (as applicable)**
× **Anesthesia Conversion Factor**
= **Anesthesia Reimbursement Rate**

Base Units

The IHCP has assigned base unit values to each anesthesia service CPT code (00100–01999). The IHCP reimbursement value for anesthesia base units matches the 2014 Medicare base unit value.

Note:	*Providers do not report the base units on claims. The Core Medicaid Management Information System (CoreMMIS) automatically determines the base units for the procedure code as submitted on the claim.*

Time Units

For anesthesia service codes, providers should indicate the actual duration of the service rendered, in minutes, in the units field of the *CMS-1500* claim form, Portal professional claim, or 837P electronic transmission. *Core*MMIS calculates the time units, and it allows **one unit for each 15-minute period or fraction thereof**. (See the *Anesthesia for Vaginal or Cesarean Delivery* section for special information about time unit calculations for delivery-related anesthesia codes.)

Time starts when the anesthesiologist or certified registered nurse anesthetist (CRNA) begins preparing the patient for the procedure in the operating room or other appropriate area. Starting to count time when the preoperative examination occurs is not appropriate. IHCP reimbursement of the preoperative exam is included in the base units. Time ends when the anesthesiologist or CRNA releases the patient to the postoperative unit and is no longer in constant attendance.

Additional Units

*Core*MMIS, the claim-processing system, recognizes and calculates additional units for the following:

- **Patient age** – *Core*MMIS applies additional units to the base units for members under 1 year of age or more than 70 years old.
- **Emergency conditions (procedure code 99140)** – Additional reimbursement may be added to the rate if CPT codes for emergency (99140 – *Anesthesia complicated by emergency conditions*) or other qualifying circumstances are also billed. Only one unit of CPT code 99140 is reimbursable for each anesthesia event. Claims billed for two or more units of CPT code 99140 for a single anesthesia event are cut back to one unit for reimbursement. Providers should bill this service on a separate line item of the claim to indicate that the anesthesia provided was complicated by emergency conditions. The maximum reimbursement for one unit of CPT code 99140 is equivalent to two base anesthesia units.
- **Physical status** – Providers should use the appropriate status modifier to denote any conditions described in the modifier descriptions listed in Table 1.

Table 1 – Physical Status Modifiers – Anesthesia

Modifier	Description	Additional Units Allowed
P1	A normal healthy patient	0 units
P2	A patient with mild systemic disease	0 units
P3	A patient with severe systemic disease	1 unit
P4	A patient with a severe systemic disease that is a constant threat to life	2 units
P5	A moribund patient who is not expected to survive without the operation	3 units
P6	A declared brain-dead patient whose organs are being removed for donor purposes	0 units

Anesthesia Conversion Factor

The total unit value (which is the sum of time units, base units, and any additional units) is multiplied by the IHCP conversation factor to arrive at the reimbursement rate. The IHCP anesthesia conversion factor is $16.26, which is 75% of the 2014 Medicare anesthesia conversion factor.

CRNA, Anesthesiologist Assistant, and Medical Direction Billing and Reimbursement

The IHCP reimburses for services rendered by a CRNA or an anesthesiologist assistant, as well as for an anesthesiologist's medical direction of such services (if applicable), at reduced rates:

- Anesthesia services that are rendered by a CRNA or an anesthesiologist assistant are priced at 60% of the allowed amount.
- Medical direction of rendered services by an anesthesiologist is priced at 30% of the allowed rate.

See the following sections for applicable billing and reimbursement requirements.

CRNA and Anesthesiologist Assistant Requirements

CRNAs must bill using the procedure codes listed on the *Procedure Code Set for Certified Registered Nurse Anesthetists (Specialty 094)* table in *Anesthesia Services Codes*, accessible from the Code Sets page at in.gov/medicaid/providers.

When CRNA-rendered services are billed under the anesthesiologist's National Provider Identifier (NPI), the appropriate procedure code modifier must be used to identify that the service was rendered by a CRNA:

- QX – *CRNA service: with medical direction by a physician*
- QZ – *CRNA service: without medical direction by a physician*

CRNAs billing with their individual rendering NPI do not need to use the QX or QZ modifiers.

*Note: CRNAs use the same **physical status** modifiers that apply to the anesthesiologist.*

Anesthesiologist assistant-rendered services must be billed using the anesthesiologist's NPI and the QX modifier.

Medical Direction Requirements

In accordance with *Indiana Administrative Code 405 IAC 5-10-3(i)*, IHCP reimbursement is available for medical direction of a procedure involving an anesthetist (defined in the IAC as an anesthesiologist assistant or a CRNA) only when the direction is by an anesthesiologist, and only when the anesthesiologist medically directs two, three, or four concurrent procedures involving qualified anesthetists. Anesthesiologists billing for medical direction must use modifier QK – *Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals*.

Reimbursement is not available for medical direction in cases in which an anesthesiologist is concurrently administering anesthesia and providing medical direction. An anesthesiologist involved in medically directing more than one and up to four procedures cannot be personally performing procedures at the same time.

Criteria for medical direction include the following:

- Ensure that only qualified individuals administer the anesthesia.
- Monitor anesthesia at frequent intervals.
- Participate in the most demanding portions of the procedures, including induction and emergence, if applicable.
- Perform the preoperative evaluation.
- Perform the postoperative evaluation.
- Prescribe an anesthesia plan.
- Remain immediately available and do not perform other services concurrently.

Coverage and Billing for Specific Anesthesia Services

The following sections provide coverage and billing information for particular anesthesia services.

Regional Anesthesia

When billing regional anesthesia **as the anesthesia type for a given surgical procedure**, providers bill the regional anesthesia in the same manner as a general anesthetic, such as base units plus time. Regional anesthesia billed in this manner is reimbursed the same way as general anesthesia.

Providers should bill neuraxial blocks that are performed **as a surgical procedure for the treatment of a condition**, such as chronic pain, with the appropriate neuraxial block code, quantity of one, with no anesthesia modifier.

Monitored Anesthesia Care

IHCP reimbursement is available for medically reasonable and necessary monitored anesthesia care (MAC) services on the same basis as other anesthesia services.

To identify the services as MAC, providers must append an appropriate modifier to the appropriate CPT code, in addition to other applicable modifiers. Appropriate MAC modifiers include the following:

- QS – *Monitored anesthesia care services*
- G8 – *Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure*
- G9 – *Monitored anesthesia care (MAC) for a patient who has a history of severe cardiopulmonary condition*

MAC also includes the following:

- Performance of a preanesthestic examination and evaluation
- Prescription of the anesthesia care required
- Administration of any necessary oral or parenteral medications, such as Atropine, Demerol, or Valium
- Provision of indicated postoperative anesthesia care

Anesthesia for Vaginal or Cesarean Delivery

Providers billing anesthesia services for labor and delivery use the anesthesia CPT codes for vaginal or cesarean delivery. Billing for obstetrical anesthesia is the same as for any other surgery, regardless of the type of anesthesia provided (such as general or regional), including epidural anesthesia.

When the anesthesiologist starts an epidural for labor, and switching to a general anesthetic for the delivery becomes necessary, the provider should combine and bill the total time for the procedure performed, such as vaginal delivery or cesarean section (C-section).

*Core*MMIS calculates total units by adding base units to the number of time units, which are calculated by the system based on the number of minutes billed on the claim. *Core*MMIS converts each 15-minute block of time to one time unit.

However, for the following procedure codes, *Core*MMIS calculates one time unit for each 15-minute block of time billed in the first hour of service and, for subsequent hours of service, calculates one unit of service for every 60-minute block of time or portion billed:

- 01960 – *Anesthesia for vaginal delivery only*
- 01967 – *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)*

When a provider other than the surgeon or obstetrician bills for epidural anesthesia, the IHCP reimburses that provider in the same manner as for general anesthesia.

Anesthesia for Sterilization Services

See the *Family Planning Services* module for information about the *Consent for Sterilization* form that must accompany all claims for voluntary sterilization and related services, including services provided by anesthesiologists. *Family Planning Services Codes*, accessible from the *Code Sets* page at in.gov/medicaid/providers includes procedure codes and diagnosis codes that suspend for analyst review of the consent form.

For members enrolled in the Family Planning Eligibility Program, see the *Family Planning Eligibility Program* module for billing and coverage information specific to that program.

Anesthesia for Dental Procedures

For information about anesthesia for dental procedures, see the *Dental Services* module.

Postoperative Pain Management

The IHCP reimburses for postoperative epidural catheter management services using CPT code 01996 – *Daily hospital management of continuous spinal drug administration*. The IHCP does not pay separately for CPT code 01996 on the same day the epidural is placed. Rather, providers should bill this code on subsequent days when the epidural is actually being managed. Providers should use this code for daily management of patients receiving continuous epidural, subdural, or subarachnoid analgesia. The IHCP limits this procedure to one unit of service for each day of management. CPT code 01996 is only reimbursable during active administration of the drug. Providers should not append a modifier when this procedure is monitored by an anesthesia provider.

Postoperative pain management codes, when submitted with an anesthesia procedure code and performed on the same day as surgery, must be billed in conjunction with the most appropriate modifier listed in Table 2. These claims are subject to postpayment review.

Table 2 – Modifiers Used for Postoperative Pain Management and Anesthesia Performed on Same Day as Surgery

Modifier	Description
59	Distinct procedural service
XE	Separate encounter; a service that is distinct because it occurred during a separate encounter
XP	Separate practitioner; a service that is distinct because it was performed by a different practitioner
XS	Separate structure; a service that is distinct because it was performed on a separate organ/structure
XU	Unusual non-overlapping service; the use of a service that is distinct because it does not overlap usual components of the main service