Anesthesia Services

Surgical anesthesia services may be provided by anesthesiologists or certified registered nurse anesthetists (CRNAs). Maternity-related anesthesia services may be provided by anesthesiologists, CRNAs, or the delivering physician.

Procedure codes in the Anesthesia section of the *Current Procedural Terminology* (CPT) manual are to be used to bill for surgical anesthesia procedures.

- Reimbursement for surgical anesthesia procedures will be based on formulas utilizing base units, time units (1= 15 min) and a conversion factor.
- Reimbursement for moderate sedation and maternity-related procedures, other than general anesthesia for vaginal delivery, will be a flat fee.
- Minutes must be reported on all anesthesia claims except where policy states otherwise.

The following modifiers are to be used to bill for surgical anesthesia services:

Modifier	Servicing Provider	Surgical Anesthesia Service
AA	Anesthesiologist	Anesthesia services performed personally by the anesthesiologist
QY	Anesthesiologist	Medical direction* of one CRNA
QK	Anesthesiologist	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals
QX	CRNA	CRNA service with direction by an anesthesiologist
QZ	CRNA	CRNA service without medical direction by an anesthesiologist

*See Medical Direction for further explanation.

The following is an explanation of billable modifier combinations:

- Modifiers which can stand alone: AA and QZ.

- Modifiers which need a partner: QK, QX and QY.
- Legitimate combinations: QK and QX
  QY and QX

Medical Direction

Medical direction is defined as:

- Performing a pre-anesthetic examination and evaluation,
- Prescribing the anesthesia plan,
- Participating personally in the most demanding procedures in the anesthesia plan, including induction and emergence,
- Ensuring that any procedures in the anesthesia plan that he/she does not perform are rendered by a qualified individual,
- Monitoring the course of anesthesia administration at frequent intervals,
- Remaining physically present and available for immediate diagnosis and treatment of emergencies, and
- Providing the indicated post-anesthesia care.

Only anesthesiologists will be reimbursed for medical direction.

The anesthesiologist must be physically present in the operating suite to bill for direction of concurrent anesthesia procedures.

The anesthesiologist may bill for the direction of up to four concurrent anesthesia procedures for straight Medicaid recipients.

NOTE: Reimbursement will not be made for the direction of five or more anesthesia procedures being performed concurrently unless the recipient is a Medicare/Medicaid beneficiary.

Maternity-Related Anesthesia

CPT codes in the Anesthesia Obstetric section of the CPT manual are to be used by anesthesiologists and CRNAs to bill for maternity-related anesthesia services. The delivering

physician should use CPT codes in the Surgery Maternity Care and Delivery section of the CPT manual to bill for maternity-related anesthesia services. Reimbursement for these services shall be a flat fee except for general anesthesia for vaginal delivery.

The following chart is an explanation of the billable modifiers used for maternity-related anesthesia, the provider type that may bill using the modifier, and the Louisiana Medicaid billing definitions.

Modifier	Provider Type That May Bill	Billing Definition
AA	Anesthesiologist	Anesthesia services performed personally by the anesthesiologist
QY	Anesthesiologist	Medical direction* of one CRNA
QK	Anesthesiologist	Medical direction of two, three, or four concurrent anesthesia procedures
QX	CRNA	CRNA service with medical direction by an anesthesiologist
QZ	CRNA	CRNA service without medical direction by an anesthesiologist
47	Delivering Physician	Anesthesia provided by delivering physician
52	Delivering Physician or Anesthesiologist	Reduced services
QS**	Anesthesiologist or CRNA	Monitored Anesthesia Care Service

*See Medical Direction for further explanation.

** The QS modifier is a secondary modifier only, and must be paired with the appropriate anesthesia provider modifier (either the anesthesiologist or the CRNA). The QS modifier indicates that the provider **did not introduce** the epidural catheter for anesthesia, but **did monitor** the recipient after catheter placement.

Billing Add-on Codes for Maternity-Related Anesthesia

When an add-on code is used to fully define a maternity-related anesthesia service, the date of delivery should be the date of service for both the primary and add-on code.

An add-on code in and of itself is not a full service and cannot be reimbursed separately to different providers.

A group practice frequently includes anesthesiologists and/or CRNA providers. One member may provide the pre-anesthesia examination/evaluation, and another may fulfill other criteria. The medical record must indicate the services provided and must identify the provider who rendered the service. A single claim must be submitted showing one member as the performing provider for all services rendered. Billing of these services separately will not be reimbursed.

Billing for Maternity-Related Anesthesia

Use the following chart when:

- The anesthesiologist performs complete service, or just supervision of the CRNA; **OR**
- The CRNA performs complete service with or without supervision by the anesthesiologist.

TYPE OF ANESTHESIA	CPT CODE	MODIFER	TIME	REIMBURSEMENT
Vaginal Delivery General Anesthesia	01960	Valid Modifier	Record Minutes	Formula
Epidural for Vaginal Delivery	01967	AA or QZ	Record Minutes	$324.00
		QK or QY		$162.00
		QX		$162.00
Cesarean Delivery, only (epidural or general)	01961	AA or QZ	Record Minutes	$403.76
		QK or QY		$201.88
		QX		$201.88

Cesarean Delivery after Epidural, for planned vaginal delivery	01967 + 01968	AA or QZ	Record Minutes	$324.00 $79.76
		QK or QY		$162.00 $39.88
		QX		$162.00 $39.88
Cesarean Hysterectomy after Epidural and Cesarean Delivery	01967 + 01969	AA or QZ	Record Minutes	$324.00 $79.76
		QK or QY		$162.00 $39.88
		QX		$162.00 $39.88

Vaginal Delivery – Complete Anesthesia Service by Delivering Physician

Use the following chart when the delivering physician provides the **entire** anesthesia service for a vaginal delivery. The most appropriate code from codes 59410, 59610, 59612 and 59614 should be billed with modifier "47." The delivering physician should bill delivery and anesthesia on a single claim line. Reimbursement for both services will be made in a single payment.

TYPE OF ANESTHESIA	CPT CODE	MODIFIER	TIME	ADDITIONAL REIMBURSEMENT for Anesthesia
Epidural	59410 59610 59612 59614	47	Record minutes	$325.08

Vaginal Delivery – Shared

Use the following charts when the anesthesia service for **vaginal** delivery is shared by:

- The delivering physician and the anesthesiologist/CRNA, **OR**
- The anesthesiologist and CRNA

Introduction Only by Delivering Physician

TYPE OF ANESTHESIA	CPT CODE	MODIFER	TIME	ADDITIONAL REIMBURSEMENT for Anesthesia
Epidural	59410 59610 59612 59614	47and 52	Record minutes	$178.20

Introduction Only by Anesthesiologist

TYPE OF ANESTHESIA	CPT CODE	MODIFER	TIME	REIMBURSEMENT
Epidural	01967	AA and 52	Record minutes	$178.20

Monitoring by Anesthesiologist or CRNA

TYPE OF ANESTHESIA	CPT CODE	MODIFER	TIME	REIMBURSEMENT
Epidural	01967	AA and QS or QZ and QS Or QX and QS	Record minutes	$145.80

Cesarean Delivery – Shared

Use the following charts when the anesthesia service for **cesarean** delivery is shared by:

- The delivering physician and the anesthesiologist/CRNA, **OR**
- The anesthesiologist and CRNA

Introduction Only by Delivering Physician

TYPE OF ANESTHESIA	CPT CODE	MODIFER	TIME	ADDITIONAL REIMBURSEMENT for Anesthesia
Most appropriate	59515, 59618, 59620 or 59622	47 and 52	Record minutes	$217.80

Introduction Only by Anesthesiologist

TYPE OF ANESTHESIA	CPT CODE	MODIFER	TIME	REIMBURSEMENT
C Delivery after Epidural	01961	AA and 52	Record Minutes	$213.99
C Delivery following epidural for planned vaginal delivery	01967 +01968	AA and 52	Record minutes	$178.20 $35.89

Monitoring by Anesthesiologist or CRNA

TYPE OF ANESTHESIA	CPT CODE	MODIFER	TIME	REIMBURSEMENT
C Delivery after Epidural	01961	AA and QS Or QZ and QS Or QX and QS	Record minutes	$189.77
C Delivery following epidural for planned vaginal delivery	01967 +01968	AA and QS Or QX and QS	Record minutes	$145.80 $43.87

C Delivery following epidural for planned vaginal delivery	01967 +01968	QZ and QS or QX and QS	Record minutes	$145.80 $43.86

Anesthesia for Tubal Ligation or Hysterectomy

Anesthesia reimbursement for tubal ligations and hysterectomies is formula-based with the exception of anesthesia for cesarean hysterectomy (CPT code 01969).

The reimbursement for CPT codes 01967 and 01969 when billed together will be a flat sum of $403.76. CPT code 01968 is implied in CPT code 01969 and should not be placed on the claim form if a cesarean hysterectomy was performed after C-section delivery.

Anesthesiologists and CRNAs must attach the following forms for reimbursement:

- For a sterilization procedure – Form OMB No. 0937-0166, "Consent to Sterilization"
- For a hysterectomy – Form 96-A, "Acknowledgement of Receipt of Hysterectomy Information"

Pain Management

Epidurals that are administered for the prevention or control of acute pain, such as that which occurs during delivery or surgery, are covered by the Professional Services Program for this purpose only. **Epidurals given to alleviate chronic, intractable pain are not covered.**

If a recipient requests treatment for chronic intractable pain, the provider may submit a claim for the initial office visit. Subsequent services that are provided for the treatment or management of this chronic pain are not covered and are billable to the recipient. Claims paid inappropriately are subject to recoupment.

Pediatric Moderate (Conscious) Sedation

Claims for moderate sedation should be submitted hard copy indicating the medical necessity for the procedure. Documentation should also reflect pre- and post-sedation clinical evaluation of the recipient.

Moderate sedation does not include minimal sedation (anxiolysis), deep sedation or monitored anesthesia care.

Moderate sedation is restricted to recipients from birth to age 13. (Exceptions to the age restriction will be made for children who are severely developmentally disabled with documentation attached to support this condition. No claims will be considered for recipients twenty-one years of age or older).

Moderate sedation includes the following services (which are not to be reported/billed separately):

- Assessment of the recipient (not included in intra-service time),
- Establishment of IV access and fluids to maintain patency, when performed,
- Administration of agent(s),
- Maintenance of sedation,
- Monitoring of oxygen saturation, heart rate and blood pressure, and
- Recovery (not included in intra-service time).

Intra-service time starts with the administration of the sedation agent(s), requires continuous face-to-face attendance, and ends at the conclusion of personal contact by the physician providing the sedation.

Louisiana Medicaid has adopted CPT guidelines for all moderate sedation services and procedures that include moderate sedation as an inherent part of providing the procedure.

Louisiana Medicaid will reimburse a second physician other than the health care professional performing the diagnostic or therapeutic when the second physician provides moderate sedation in the facility setting (e.g., hospital, outpatient hospital, ambulatory surgery center, skilled nursing facility). However, moderate sedation services performed by a second physician in the non-facility setting (e.g., physician office, freestanding imagining center) should not be reported.

Claims paid inappropriately are subject to recoupment.

Claims Filing

Most anesthesia claims may be submitted either electronically or hard copy using the CMS 1500 form. Claims which require a hard copy claim and special instructions include:

- **Anesthesia for vaginal procedures; hysteroscopy and/or hysterosalpingogram (HSG)**. Claims will pend to Medical Review and must have anesthesia record attached. The attached documentation must indicate:

    - Medical necessity for anesthesia (diagnosis of mental retardation, hysteria, and/or musculoskeletal deformities that would cause procedural difficulty), and
    - That the hysterosalpingogram meets the criteria for that procedure (Refer to the Medical Review section)

- **Claims with a total anesthesia time of less than 10 minutes or greater than 224 minutes**. Submit a hard copy claim with the appropriate anesthesia graph attached.

- **Claims for multiple but <u>separate</u> operative services performed on the same recipient on the same date of service**. Submit a hard copy claim with a cover letter explaining the circumstances and medical necessity. Attach anesthesia graphs from surgical procedures to the fiscal intermediary's Provider Relations Unit.

- **Claims that deny with error codes 749 (delivery billed after hysterectomy was done) or 917 (lifetime limits for this service have been exceeded)**. A new claim must be submitted to the fiscal intermediary's Provider Relations Unit with a cover letter explaining the situation which seemed to have caused the original claim denial.

NOTE: See Appendix A for the fiscal intermediary contact information.

Anesthesia time begins when the provider begins to prepare the recipient for induction and ends with termination of the administration of anesthesia. Time spent in pre- and postoperative care may not be included in the total anesthesia time.

All CRNAs must place the name of their supervising doctor in Item 17 of the CMS 1500 or 837P claim form.

If the billing provider is a group practice that includes multiple anesthesiologists and/or CRNAs, one member may provide the pre-anesthesia examination/evaluation and another may fulfill other criteria. The medical record must indicate the services provided and must identify the provider who rendered the service. A single claim must be submitted showing one member as the performing provider for all services rendered. The billing of these services separately will not be reimbursed.

Anesthesia for multiple surgical procedures in the same anesthesia session must be billed on one claim line using the most appropriate anesthesia code with the total anesthesia time spent reported in item 24G on the claim form. **The only secondary procedures that are not to be billed in this manner are tubal ligations and hysterectomies**.

Anesthesia for dental restoration should be billed under the appropriate CPT anesthesia code with the appropriate modifier, minutes and most specific diagnosis code. Reimbursement is formula-based, with no additional payment being made for biopsy. A provider does not have to perform a biopsy to bill this code.

A surgeon who performs a surgical procedure will not also be reimbursed for the administration of anesthesia for the procedure.

Anesthesia for arteriograms, cardiac catheterizations, CT scans, angioplasties and/or MRIs should be billed with the appropriate code from the Radiological Procedures sub-heading in the Anesthesia section of the CPT.

Reimbursement

Current reimbursement rates for all anesthesia procedure codes, including those reimbursed at a flat fee can be found on the Anesthesia Fee Schedule. (See Appendix A for information about how to access the Anesthesia Fee Schedule)