ANESTHESIA SERVICES

Policy
Neighborhood Health Plan reimburses participating providers for the administration of general and regional anesthesia and supportive services performed in conjunction with covered obstetrical, surgical, and medical procedures for optimal anesthesia care to the member.

The following payment policy does not apply to anesthesia performed with acupuncture. Please refer to the Acupuncture Payment Policy Guideline for further information.

Policy Definition
Reimbursement is made for the provision of regional or general anesthesia services provided by an anesthesiologist and supervision and/or direction of CRNA (certified registered nurse anesthetists) by an anesthesiologist.

Reimbursement
Providers are reimbursed according to the plan’s network provider reimbursement or contracted rates. Claims are subject to payment edits that are updated at regular intervals.

Covered services are defined by the member’s benefit plan. The manner in which covered services are reimbursed is determined by the Neighborhood Health Plan Payment Policy and by the provider’s agreement with NHP. Member liability amounts may include, but are not limited to, copayments, deductible, and/or co-insurance, and will be applied dependent upon the member’s benefit plan.

Various services and procedures require referral and/or authorization. Referral and authorization requirements can be located here.

Please reference procedure codes from the current CPT, HCPCS Level II, and ICD-10-CM manuals, as recommended by the American Medical Association (AMA), the Centers for Medicare & Medicaid Services (CMS), and the American Hospital Association. CMS and the AMA revise HIPAA medical codes on a pre-determined basis, including changes to CPT, HCPCS, and ICD-10 codes and definitions.

Please refer to the CMS or CPT guidelines for requisite modifier usage when reporting services. The absence or presence of a modifier may result in differential claim payment or denial.

NHP reviews claims to determine eligibility for payment. Services considered incidental, mutually exclusive, integral to the primary service rendered, or part of a global allowance, are not eligible for separate reimbursement. Please refer to Coding Provider Payment Guidelines for more information.

All claims are subject to audit services and medical records may be requested from the provider.
Neighborhood Health Plan uses the American Society of Anesthesiologists (ASA) anesthesia codes and base unit system to calculate professional reimbursement. Please refer to CMS Anesthesiologists Center for more information and to retrieve base units. The ASA updates its anesthesia base units annually.

NHP calculates anesthesia reimbursement by adding the ASA base value for the primary procedure to the number of units (total minutes divided by 15 minute intervals) multiplied by the conversion factor. Please refer to the calculation formula below:

(Anesthesia Base Units as defined by ASA + Time Units as reported by the Provider) X Conversion Factor = Payment

**Limitations**

Pre-anesthesia Evaluation and Management (E/M) services are included in the primary anesthesia code, unless no anesthesia services are provided. If a surgery does not occur the pre-operative visit is reimbursed based on a CPT evaluation and management code.

Anesthesia services comprise anesthesia care during the procedure, the administration of fluids and/or blood and the usual monitoring services including: ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry.

**Definitions**

**Anesthesia Time Unit:** A time unit equals one 15 minute segment of time during which an anesthetic is administered. Anesthesia time starts when the anesthesiologist begins to prepare the patient for care in the operating room or in an equivalent area (the anesthesia in the equivalent area must be continuous with the anesthesia in the operating room). Partial 15 minute increments of 7.49 minutes or less are rounded down. Partial 15 minute increments of 7.50 minutes or more are rounded up. If less than 7.50 total minutes of a unit of time is billed, it will be reimbursed as one billable time unit.

**Discontinuous Anesthesia Time:** When counting anesthesia time, the anesthesiologist can add blocks of anesthesia time around an interruption in anesthesia time as long as the anesthesiologist is furnishing continuous anesthesia care within the time periods around the interruption. The medical record should be documented so that a medical record auditor can see the continuous and discontinuous periods that the reported total anesthesia time sums to the segments of continuous time when the anesthesiologist was present. For example: 1) The anesthesiologist has begun preparing the patient for induction, but the surgeon is temporarily unavailable and the anesthesiologist leaves the patient under the observation of the operating room nurse, and 2) an IV is started in the induction room and there may be a break before induction of anesthesia in the operating room. As long as there is continuous monitoring of the patient within the blocks of anesthesia time, those blocks may be aggregated.
Neighborhood Health Plan Reimburses

- Anesthesia services involving administration of anesthesia, with the use of the anesthesia five digit CPT code (00100 to 01999)
- The following, separately, based on the appropriate medical or surgical fee schedule:
  - CPT 93503  Placement of a Swan-Ganz catheter for monitoring purposes
  - CPT 36620  Insertion of an intra-arterial monitoring line during surgery
  - CPT 36556  Insertion of a central venous pressure monitor during surgery
- Certified Registered Nurse Anesthetists (CRNA) only when medically directed or supervised by a physician, identified by appending modifier QX to the procedure code

Neighborhood Health Plan Does Not Reimburse

- Anesthesia by surgeon: Modifier 47
- Anesthesia stand by services
- Anesthesia qualifiers: CPT codes 99100-99140
- Anesthesia physical status modifiers: P1-P6
- Catheter insertion on the same day as epidural anesthesia delivery for surgery
- CPT codes designated by the ASA as “anesthesia care not normally required” or “not a primary procedure code”
- CRNA services without medical direction by a physician: Modifier QZ
- CRNA services performed by salaried facility employees
- Evaluation and management services for post-operative pain control on the day of surgery
- Evaluation and management services as part of the routine pre- and post-operative anesthetic service
- Local anesthesia which is considered part of the surgical procedure
- Inpatient pain management on the same day as epidural catheter insertion or a single epidural insertion
- Moderate (conscious) sedation (CPT codes 99143-99150) when billed with a procedure that includes conscious sedation
- Pain management outside post-operative pain control
- Post-operative pain management on the day of surgery (See section: Post-Operative Care (Inpatient) below)

CPT/HCPCS Codes

Note: This list of codes may not be all-inclusive

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>01960</td>
<td>Anesthesia for vaginal delivery only</td>
<td>Denied when submitted with CPT 01967</td>
</tr>
<tr>
<td>01961</td>
<td>Anesthesia for cesarean delivery only</td>
<td>Denied when submitted with CPT 01967-01968</td>
</tr>
<tr>
<td>01967</td>
<td>Neuraxial labor analgesia/anesthesia for planned vaginal delivery</td>
<td>Time unit cap applies: Base + Time for a total maximum cap of 20 units (300 minutes)</td>
</tr>
<tr>
<td>01968</td>
<td>Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia</td>
<td>Submit in addition to CPT 01967 when a planned vaginal delivery turns into a cesarean; not reimbursable when billed alone.</td>
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</tbody>
</table>
This code in addition to 01967 is subject to a time unit cap: Base + Time for a total combined maximum cap of 24 units (360 minutes)

01969 Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia
Submit in addition to CPT 01967

### Post-Operative Care (Inpatient)

<table>
<thead>
<tr>
<th>Code</th>
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<tbody>
<tr>
<td>01996</td>
<td>Daily hospital management of epidural or subarachnoid continuous drug administration</td>
<td>Separately payable on days subsequent to surgery, but inappropriate on the day of surgery when the catheter was used for delivery of the surgical anesthetic. Submit only one unit, per post-operative day, regardless of the number of visits required to manage the member. Reimbursement is one flat fee.</td>
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<tr>
<td>62310 - 62311</td>
<td>Injection, single, not including neurolytic substances, w/wo contrast, of diagnostic or therapeutic substances, epidural or subarachnoid; cervical or thoracic, lumbar, sacral (caudal)</td>
<td>Submit for post-operative pain management on the day of surgery when NOT used as the surgical anesthetic technique. Report with modifier 59 and one unit of service.</td>
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<tr>
<td>62318 - 62319</td>
<td>Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substance, w/wo contrast of diagnostic or therapeutic substances, epidural or subarachnoid; cervical or thoracic, lumbar, sacral (caudal)</td>
<td>Submit for catheter insertion for post-operative pain management on the day of surgery when NOT used as the surgical anesthetic technique. Report with modifier 59 and one unit of service.</td>
</tr>
<tr>
<td>64402</td>
<td>Injection, anesthetic agent; facial nerve</td>
<td>Not payable</td>
</tr>
<tr>
<td>64416, 64446, 64448, 64449</td>
<td>Continuous block codes</td>
<td>When reported on the day of surgery, NO additional reporting of daily pain management is allowed.</td>
</tr>
<tr>
<td>99231-99233</td>
<td>Subsequent hospital care</td>
<td>Submit for inpatient post-operative pain management services, not described above. One unit per day.</td>
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### Modifiers

Append the following anesthesia service specific modifiers to anesthesia service codes 00100 – 01999, and E/M codes submitted by anesthesiologists, as appropriate.

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Descriptor</th>
<th>Reimbursement</th>
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<tbody>
<tr>
<td>AA</td>
<td>Anesthesia services performed personally by physician</td>
<td>100% of anesthesia allowable</td>
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<tr>
<td>AD</td>
<td>Medical supervision by a physician for more than 4 concurrent procedures</td>
<td>3 base units</td>
</tr>
<tr>
<td>QK</td>
<td>Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals</td>
<td>50% of anesthesia allowable</td>
</tr>
<tr>
<td>QX</td>
<td>CRNA service with medical direction by a physician</td>
<td>50% of anesthesia allowable</td>
</tr>
<tr>
<td>QY</td>
<td>Medical direction of one CRNA by an anesthesiologist</td>
<td>50% of anesthesia allowable</td>
</tr>
<tr>
<td>QZ</td>
<td>CRNA service; without medical direction by a physician</td>
<td>Not a covered service</td>
</tr>
<tr>
<td>47</td>
<td>Anesthesia performed by surgeon</td>
<td>No additional reimbursement for</td>
</tr>
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</table>
Provider Payment Guidelines and Documentation

- Report anesthesia services involving administration of anesthesia by the use of the anesthesia five-digit CPT code (00100-01999).
- When performing multiple surgical procedures during a single anesthetic administration, report only the anesthesia code (00100 series) with the highest base unit value. The time reported is the combined total minutes for all procedures.
- Bill discontinuous blocks of anesthesia time only if the patient is continuously monitored within the discontinuous blocks of time and documentation of monitoring in the medical record supports the time billed.
- An anesthesia time unit equals on 15 minute segment of time during which an anesthetic is administered. Partial 15 minute increments are: rounded down for 7.49 minutes or less, or rounded up for 7.50 minutes or more. If less than 7.50 total minutes of a unit are billed, it is reimbursable as one billable time unit.
- Submit time in total minutes from the beginning to the end of clock time for the anesthesia service. Do NOT submit time units or add the base value to the total minutes billed. This will cause overpayment resulting in a post audit recovery.
- Obstetrical anesthesia reimbursement for neuraxial/epidural labor is based on the base units + time units capped at the following units/minutes:
  - Vaginal delivery code 01967 – capped at a maximum of 20 units (300 minutes). The maximum units include base time.
  - Cesarean section delivery code 01968 – capped at a maximum of 24 units (360 minutes). This is combined with code 01967 for a total maximum cap. The maximum units include base time.
- Submit electronic claims using the designated minute field; use three digits to record minutes (e.g. 22 minutes would be correctly submitted as 022, 124 minutes as 124)

Related NHP Payment Guidelines
NHP Evaluation and Management Services
NHP Acupuncture Services

References
American Society of Anesthesiology Crosswalk: A Guide for Surgery/Anesthesia CPT Codes
CMS Chapter II, Anesthesia Services CPT Codes 00100-01999 for National Correct Coding Initiative Policy Manual
Medicare Claims Processing Manual, Chapter 12.50 Payment for Anesthesiology Services
Publication History

<table>
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<tr>
<th>Topic: Anesthesia Services</th>
<th>Owner: Provider Network Management</th>
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<tr>
<td>July 21, 2009</td>
<td>Original documentation</td>
</tr>
<tr>
<td>August 3, 2010</td>
<td>Procedure Codes Tables updated</td>
</tr>
<tr>
<td>February 1, 2012</td>
<td>Disclaimer and Referral Grid updated</td>
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<tr>
<td>March 16, 2012</td>
<td>Referral Grid updated</td>
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<tr>
<td>February 23, 2016</td>
<td>Obstetrical Anesthesia, Procedures, Definitions and Payment Guidelines updated</td>
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This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider’s agreement, the terms and conditions of the provider’s agreement shall prevail. Neighborhood Health Plan utilizes clinical coding criteria and claim editing logic in addition to auditing across dates of service to identify the unbundling of pre and post-operative care.