ANESTHESIA BILLING AND REIMBURSEMENT POLICY
Payment policies apply to all in-network and out-of-network providers who render services to Neighborhood Health Plan of Rhode Island subscribers covered under the following products: Rite-Care (MED, CSN, SUB, RHP, EFP), Rhody Health Options (RHO), Medicaid Expansion (RHE) and Health Benefit Exchange (HBE). Benefit coverage limits may apply. It is the provider's responsibility to verify eligibility, coverage and authorization criteria prior to rendering services. Member copayments, coinsurance and deductibles may apply based on neighborhood product.

DISCLAIMER:

This guideline is informational only, and not a guarantee of reimbursement. Claims payment is subject to Neighborhood Health Plan of RI benefit coverage, member eligibility, claim payment edit rules, coding and documentation guidelines, authorization policies, provider contract agreements and state or federal regulations. All services billed to Neighborhood for reimbursement is subject to audit. Effective dates noted reflects the date the long standing policy was documented or updated to assist with provider education, unless otherwise noted.

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A. GENERAL BILLING INFORMATION

Electronic (EDI) HIPPA 5010 compliant 837P format claim submission

- Submit total time in minutes in the appropriate field

Paper claim submission

- Submit claim using the most current CMS-1500 form.
- Submit total minutes in the unit field.
- Submit actual start and stop time (ex. 12:00 to 13:00 or 12:00 pm to 1:00 pm) on the claim form above the anesthesia CPT code field.

All claims for anesthesiologists and CRNAs must be billed under the name and National Provider Identifier (NPI) of the provider who actually rendered the service. "Incident to" billing for anesthesia services is not recognized by Neighborhood. All providers should render services based on the scope of their particular license.

**Anesthesia Service Codes ****not an all-inclusive list*

CPT Code - 00100 to 00936, 00940 to 01999, 62273, 99100 to 99150
HCPCS Code - D9220, D9221 (D-codes only covered for oral surgery)

**Anesthesia Modifiers ****not an all-inclusive list. See Modifier policy for a complete list*

Modifiers must be billed with anesthesia procedure codes to indicate whether the procedure was personally performed, medically directed or medically supervised.
Service will deny:

- When billed without appropriate modifier for provider's specialty
- When modifier is not billed in the appropriate modifier position.
- When billed with invalid modifier combinations. (*see incorrect modifier billing combination grid below)*
- If not billed in accordance with standard coding/billing guidelines and Neighborhood's policies

Incorrect Billing Modifiers

Modifier	Do Not file on the same claim line with:
AA – *Anesthesiologists*	AD, QY, QK, QX, or QZ
QY – *Anesthesiologists*	AA, AD, QK, QX, or QZ
QK – *Anesthesiologists*	AA, AD, QY, QX, or QZ
AD – *Anesthesiologists*	AA, QY, QK, QX, or QZ
QX – *CRNAs*	AA, AD, QY, QK, or QZ
QZ – *CRNAs*	AA, AD, QY, QK, or QX

Required Modifiers

Required Modifiers for Anesthesiologist	Description	Reimbursement
AA	Anesthesia services personally performed by anesthesiologist	100 percent of allowable amount
AD	Medical supervision by a physician, more than four concurrent anesthesia procedures	Max 3 base units + time units) effective 10/1/2014 date of service
QK	Medical direction of two, three or four concurrent anesthesia procedures	50 percent of allowable amount effective 10/1/2014 date of service
QY	Medical direction of one C.R.N.A by anesthesiologist	50 percent of allowable amount effective 10/1/2014 date of service
Required-Modifiers-For CRNAs		
QX	Qualified non-physician anesthetist with medical direction by physician.	80 percent of the payment made for the QK or QY claim effective 10/1/2014 date of service
QZ	CRNA service, without medical direction by anesthesiologist	80 percent of allowable amount effective 10/1/2014 date of service

All other modifiers do not affect reimbursement and should not be billed in the primary modifier position. Claims will deny if not billed appropriately.

B. REIMBURSEMENT GUIDELINES

Neighborhood will reimburse covered, medically necessary anesthesia services performed in conjunction with covered authorized surgical procedures when performed by qualified and licensed medical doctor and certified registered nurse anesthetist (CRNA). Out-of-network providers may require separate authorization when billing separately

Services Included in Global Anesthesia Care (not reimbursed separately)

- Anesthesia that is integral to the surgical procedure
- Evaluation and management for post op pain management or routine pre or post-op anesthesia service.
- Post-operative pain management on the same day as surgical procedure
- Maintenance of open airway and ventilator measurements and monitoring
- Monitoring of electrocardiograms (EKGs), pulse breathing, blood pressure, electroencephalogram and other neurological monitoring;
- Monitoring of left ventricular or valve function via transesophageal echocardiogram (TEE);
- Monitoring of intravascular fluids (IVs), blood administration and fluids used during cold cardioplegia through non-invasive means;
- Anesthetic or analgesic administration;
- Local anesthesia during surgery

Anesthesia claims are paid based on the following:
Time units + Base unit x Anesthesia Conversion factor. Neighborhood uses the Centers for Medicare and Medicaid Services (CMS) base unit values.

- Anesthesia Personally Performed by Anesthesiologist or CRNA (AA or QZ Modifier) (Total Time Units + Base Unit) x Anesthesia Conversion Factor x Modifier Adjustment = Allowance
- Anesthesia Performed under Medical Direction (QK, QX and QY modifiers) [(Total Time Units + Base Unit) x Anesthesia Conversion Factor] x Modifier Adjustment = Allowance for each provider

See Required Modifier grid above for "modifier adjustment" percentages

Anesthesia start time is defined as the time the anesthesiologist begins the preparation of the patient. Anesthesia end time is defined as the time when the patient is placed under post-operative care. Time anesthesiologist is not in personal attendance is non-billable. Do not submit base unit values in the total minutes or units field on a claim. Base units are automatically calculated and paid in Neighborhood reimbursement.

Calculating Time Units for Anesthesia Services and Rounding

Submit 1 unit for every 15-minute interval, rounding up to the next unit for 8 to 14 minutes, rounding down for 1 to 7 minutes.

Number of Minutes Service is Provided	Number of Units to Bill
7 minutes or Less	Do not Bill
8 minutes to < 23 minutes	1 unit
23 minutes to < 38 minutes	2 units
38 minutes to < 53 minutes	3 units
53 minutes to < 68 minutes	4 units
68 minutes to < 83 minutes	5 units
83 minutes to < 98 minutes	6 units
98 minutes to < 113 minutes	7 units
113 minutes to < 128 minutes	8 units

Obstetrical Anesthesia Services * *not an all-inclusive list*
Anesthesia administered by the delivering physician is included in the global maternity fee and will not be reimbursed separately.

Code	Description	Reimbursement
01960	Anesthesia for vaginal delivery only	Time based.
01961	Anesthesia for cesarean delivery only	Time based
01967	Neuraxial labor analgesia/anesthesia for planned vaginal delivery	Time based
01968	Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia	Time based add-on code. Not paid when billed alone.
01969	Monitored anesthesia care	Time based add-on code. Not paid when billed alone.

Effective 8/1/2014 – Reimbursement for the following codes will be capped at the time units listed no matter the time units billed. Provider must continue to bill the actual time the service was rendered. Neighborhood will apply the cap during processing.

- Vaginal delivery code 01967 is capped at a maximum of 28 units or 420 minutes
- Cesarean section delivery add-on code 01968 is capped at a maximum 4 units or 60 minutes

Multiple/Duplicate Anesthesia Services on the Same Day

Submit only the highest base-unit value service with the total time spent for all procedures when multiple anesthesia services are administered on the same patient on the same date of service. Duplicate services will not be reimbursed.

Certified Registered Nurse Anesthetists (CRNA) Services

Neighborhood will require all CRNA(s) to become individually credentialed
Effective 10/1/2014 Neighborhood will begin reimbursing CRNA services at a percentage of anesthesia allowable. CRNA must be credentialed on the date of service in order to receive reimbursement for the service and all claims must be billed using the CRNA's NPI as rendering provider.

When a CRNA and a medically directing anesthesiologist provide services for a single anesthesia procedure, submit claims as follows:

- Submit separate claims for each practitioner using his/her NPI number
- Submit the same CPT procedure code and time on both claims
- Add to the procedure code on the supervising anesthesiologist's claim:

Modifier	Description
QY	Medical direction of one CRNA by an anesthesiologist

- Add to the procedure code on the medically directed CRNA's claim:

Modifier	Description
QX	CRNA service; with medical direction by a physician

-Payment would be 50 percent of the allowable amount of the service to the anesthesiologist and 80 percent of the anesthesiologist's payment will be paid to the CRNA.

Example:

Procedure XXXX allowable is $100.00
Anesthesiologist payment is $50.00
CRNA payment is $50.00 x 80% = $40.00

When an anesthesiologist medically directs or supervises more than one CRNA, submit claims as follows:

- Submit separate claims for each practitioner using his/her NPI number
- Submit the same CPT procedure code and time on both claims
- Add to the procedure code on the supervising anesthesiologist's claim:

Modifier Description
QK Medical direction of 2,3, or 4 concurrent anesthesia procedures.

- Add to the procedure code on the medically directed CRNA's claim:

Modifier Description
QX CRNA service; with medical direction by a physician

-Payment would be 50 percent of the allowable amount of the service to the anesthesiologist and 80 percent of the anesthesiologist's payment will be paid to the CRNA.

Example:

Procedure XXXX allowable is $100.00
Anesthesiologist payment is $50.00
CRNA payment is $50.00 x 80% = $40.00

Physical Status Modifiers

No additional reimbursement will be made when these modifiers are billed but should be submitted when appropriate

P1 Normal healthy patient
P2 Patient with mild systemic disease
P3 Patient with severe systemic disease
P4 Patient with severe systemic disease that is a constant threat to life
P5 Moribund patient who is not expected to survive without the operation
P6 Declared brain-dead patient whose organs are being removed for donor purposes

Qualifying Circumstances add-on codes

Not reimbursed separately but should be billed when appropriate

99100 – Anesthesia for Patient of Extreme Age, Under 1 Year and Over 70
99116 – Anesthesia Complicated By Utilization of Total Body Hypothermia
99135 – Anesthesia Complicated By Utilization of Controlled Hypotension
99140 – Anesthesia Complicated By Emergency Conditions

Non-reimbursable Services

Services billed by anesthesia assistants
Services provided by students
CRNA services performed by salaried facility employees

- Post-operative pain management on the same day as surgical procedure
- Anesthesia by the operating surgeon
- Anesthesia stand by
- Anesthesia for procedures not designated as requiring anesthesia
- Anesthesia for non-covered surgical procedures

C. Documentation For Anesthesia Record

General Documentation Requirements for all services:

- Anesthesia services performed, including exact time spent performing anesthesia services, must be documented in the anesthesia record to support billing.
- Rendering practitioner/qualified healthcare professional must note their credentials and legibly sign and date the record.
- Member identifying information must be present on all pages of the record.
- Documentation must be legible.

Medical Direction Documentation Requirements

For each anesthesia procedure, the anesthesiologist must document that he/she performed the following seven services and record each in the patient's anesthesia record:

1. A pre-anesthetic examination and evaluation;
2. Prescribe the anesthesia plan;
3. Personally participate in the most demanding procedures of the anesthesia plan including, if applicable, induction and emergence;
4. Ensure that any procedure in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist;
5. Monitor the course of anesthesia administration at frequent intervals;
6. Remain immediately physically present and available for immediate diagnosis and treatment of emergencies; and
7. Provide the indicated post-anesthesia care.

Medical Supervision Documentation Requirements

When the anesthesiologist does not fulfill all of the "medical direction" requirements listed above, the anesthesia services are considered medical supervision services. Documentation must indicate if the anesthesiologist was present at induction.

REFERENCES
1. Centers for Medicare and Medicaid Services (CMS) 2. American Society of Anesthesiologists (ASA) 3. Current Procedural Terminology (CPT) 4. Neighborhood Health Plan of RI benefit coverage summaries, authorization and clinical medical policies.
Please refer to Neighborhood's provider website at http://www.nhpri.org for specific provisions by product line. Guidelines are updated periodically. Refer to website for updates.

VERSION HISTORY:
Original Publication date: 8/2011 Revision date (s): 9/2013 – Format change only. 5/2014 – Format change, clarifying billing and coding information, Epidural cap limits for 01967/01968 effective 8/1/2014, Disclaimer updated. 6/2014 - CRNA credentialing requirements effective September 2014, CRNA billing and reimbursement requirements effective October 2014, clarifying billing and coding information.