



Reimbursement Policy

Subject: Professional Anesthesia Services

Effective Date: **01/03/17**

Committee Approval Obtained:
01/03/17

Section: **Anesthesia**

*****The most current version of the Reimbursement Policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to <https://providers.amerigroup.com>. Under Quick Tools, select Reimbursement Policies > Medicaid/Medicare. Note: State-specific exemptions may apply. Please refer to the Exemptions section below for specific exemptions based on your state.*****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with CPT codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current Reimbursement Policies are not followed, Amerigroup may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

Amerigroup reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, state, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Amerigroup strives to minimize these variations.

Amerigroup reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

Policy

Amerigroup allows reimbursement of anesthesia services rendered by professional providers for covered members unless provider, state, federal or CMS contracts and/or requirements indicate otherwise. Reimbursement is based upon:

- The reimbursement formula for the allowance and time

increments in accordance with CMS

- Proper use of applicable modifiers

Providers must report anesthesia services in minutes. Anesthesia claims submitted with an indicator other than minutes may be rejected or denied. Start and stop times must be documented in the member's medical record. Anesthesia time **starts** with the preparation of the member for administration of anesthesia and **stops** when the anesthesia provider is no longer in personal and continuous attendance. The reimbursement formula for anesthesia allowance is based on CMS guidelines, unless otherwise noted in the exemption section.

Anesthesia Modifiers

Anesthesia modifiers are appended to the applicable procedure code to indicate the specific anesthesia service or who performed the service. Modifiers identifying who performed the anesthesia service **must** be billed in the primary modifier field to receive appropriate reimbursement. Additional or reduced payment for modifiers is based on state requirements, as applicable. If there is no state requirement, Amerigroup will default to the following CMS guidelines. Claims submitted for anesthesiology services without the appropriate modifier will be denied.

- **Modifier AA:** Anesthesiology service performed personally by an anesthesiologist — Reimbursement is based on 100 percent of the applicable fee schedule or contracted/negotiated rate.
- **Modifier AD:** Medical supervision by a physician; more than four concurrent anesthesia procedures — Reimbursement is based on 100 percent of the applicable fee schedule or contracted/negotiated rate for up to three base units for anesthesiologists who supervise three or more concurrent or overlapping procedures.
- **Modifier QK:** Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals — Reimbursement is based on 50 percent of the applicable fee schedule or contracted/negotiated amount.
- **Modifier QX:** Certified Registered Nurse Anesthetist (CRNA) service with medical direction by a physician — Reimbursement is based on 50 percent of the applicable fee schedule or contracted/negotiated amount.
- **Modifier QY:** Anesthesiologist medically directs one CRNA — Reimbursement is based on 50 percent of the applicable fee schedule or contracted/negotiated amount.

- **Modifier QZ:** CRNA service without medical direction by a physician — Reimbursement is based on 100 percent of the applicable fee schedule or contracted/negotiated amount.
- **Modifier 23:** Denotes a procedure that must be done under general anesthesia due to unusual circumstances although normally done under local or no anesthesia — Reimbursement is based on 100 percent of the applicable fee schedule or contracted/negotiated rate of the procedure. Modifier 23 does not increase or decrease reimbursement; it substantiates billing anesthesia associated with the procedure in cases where anesthesia is not usually appropriate.
- **Modifier 47:** Denotes regional or general anesthesia services provided by the surgeon performing the medical procedure. Amerigroup does not allow reimbursement of anesthesia services by the provider performing the medical procedure (Other than obstetrical — See Obstetrical Anesthesia section of this policy); therefore, it is **not** appropriate to bill Modifier 47.

Multiple Anesthesia Procedures

Amerigroup allows reimbursement for professional anesthesia services during multiple procedures. Reimbursement is based on the anesthesia procedure with the highest base unit value and the overall time of all anesthesia procedures.

Obstetrical Anesthesia

Amerigroup allows reimbursement for professional neuraxial epidural anesthesia services provided in conjunction with labor and delivery for up to 300 minutes by either the delivering physician or a qualified provider other than the delivering physician based on the time the provider is physically present with the member. Providers must submit additional documentation upon dispute for consideration of reimbursement of time in excess of 300 minutes. This applies to markets that do not reimburse at a flat rate. Reimbursement is based on one of the following:

- For the delivering physician — Based on a flat rate or fee schedule using the surgical CPT pain management codes for epidural analgesia
- For a qualified provider other than the delivering physician — Based on:
 - The allowance calculation
 - The inclusion of catheter insertion and anesthesia administration

	<p>Services Provided in Conjunction with Anesthesia</p> <p>Amerigroup allows separate reimbursement for the following services provided in conjunction with the anesthesia procedure or as a separate service. Reimbursement is based on the applicable fee schedule or contracted/negotiated rate with no reporting of time.</p> <ul style="list-style-type: none"> • Swan-Ganz catheter insertion • Central venous pressure line insertion • Intra-arterial lines • Emergency intubation (must be provided in conjunction with the anesthesia procedure to be considered for reimbursement) • Critical care visits • Transesophageal echocardiography <p>Nonreimbursable</p> <p>Amerigroup does not reimburse for:</p> <ul style="list-style-type: none"> • Use of patient status modifiers or qualifying circumstances codes denoting additional complexity levels. • Anesthesia consultations on the same date as surgery or the day prior to surgery if part of the preoperative assessment. • Anesthesia services performed for noncovered procedures, including services considered not medically necessary, experimental and/or investigational. • Anesthesia services by the provider performing the basic procedure, except for a delivering physician providing continuous epidural analgesia. • Local anesthesia considered incidental to the surgical procedure. • Standby anesthesia services.
<p>Exemptions</p>	<ul style="list-style-type: none"> • The following markets use a reimbursement formula for anesthesia allowance based upon state guidelines: <ul style="list-style-type: none"> ○ Florida ○ Georgia ○ Kansas ○ Maryland ○ New Jersey ○ Texas ○ Washington • Amerigroup in Florida, in compliance with the Agency for Health Care Administration Medicaid Services Coverage and Limitations handbook, does the following: <ul style="list-style-type: none"> ○ Allows any portion of a 15-minute increment to equal one unit ○ Uses the following reimbursement formula for allowance calculation: anesthesia base rate plus (time divided by 15

	<p>multiplied by the conversion factor)</p> <ul style="list-style-type: none"> ○ Only recognizes Modifiers QK, QS and 78 as valid modifiers for anesthesia services. Florida anesthesia claims submitted with modifiers other than QK, QS and 78 will be denied. ○ Allows reimbursement to medically directed CRNAs based on 80 percent and to the physician billing Modifier QK based on 20 percent of the applicable fee schedule or contracted/negotiated rate ○ Allows reimbursement of anesthesia for labor and delivery time for a maximum of 360 minutes ● Amerigroup Community Care in Georgia, in compliance with Georgia Department of Community Health, does the following: <ul style="list-style-type: none"> ○ Rounds time units to the nearest whole number ○ Does not allow reimbursement of modifier AD ○ Allows additional reimbursement for physical status modifiers: <ul style="list-style-type: none"> ▪ Modifier P3: a patient with severe systemic disease — allows additional reimbursement of one (1) time unit ▪ Modifier P4: a patient with severe systemic disease that is a constant threat to life — allows additional reimbursement of two (2) time units ▪ Modifier P5: a moribund patient who is not expected to survive without the operation — allows additional reimbursement of three (3) time units ● Amerigroup Kansas, Inc., in compliance with the Kansas Medical Assistance Program (KMAP) Provider Manual: <ul style="list-style-type: none"> ○ Rounds time units up to the nearest whole number ○ Considers modifier QX as informational ○ Does not allow reimbursement for the use of the following modifiers: <ul style="list-style-type: none"> ▪ Modifier QY ▪ Modifier QK ▪ Modifier AD ● Amerigroup Community Care in Maryland does not allow reimbursement for the use of Modifier AD; Maryland claims submitted with Modifier AD will be denied ● Amerigroup Community Care in New Jersey, in accordance with the Department of Human Services, allows the AA modifier to be used for services performed by a Certified Nurse Anesthetist (CRNA) personally and directly supervised by an anesthesiologist ● Amerigroup Texas, Inc. and Amerigroup Insurance Company, in
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	<p>compliance with the Texas Medicaid Provider Procedures Manual:</p> <ul style="list-style-type: none"> ○ Does not apply modifier reduction ○ Limits neuraxial epidural anesthesia procedure codes 01960 and 01967 to once every 210 days when billed by any provider and are reimbursed a flat fee ● Amerigroup Washington Inc. allows reimbursement of anesthesia for labor and delivery time for a maximum of 360 minutes, in compliance with Washington Health Care Authority ● Medicare Advantage follows CMS national payment criteria
<p>History</p>	<p>Policy History:</p> <ul style="list-style-type: none"> ● Audit review approved 01/03/17: Florida, Georgia, Kansas, New Jersey and Texas exemptions updated ● Update due to regulatory directive (Committee approval not required in accordance with Reimbursement Policy Program Guidelines, policy #05-017): <ul style="list-style-type: none"> ○ Kansas exemption updated to not allow reimbursement of modifiers QK and AD, effective for claims processed on and after 08/01/2016 retroactive to 01/01/2013 dates of service. Claims processed prior to 08/01/2016 should not be recouped ● Effective 12/31/16: Exited Florida Medicare ● Texas exemption updated, effective 1/30/15 ● Effective 06/01/14: Exited Ohio ● Virginia exemption removed, effective 05/30/13 ● Review approved 02/25/13: Kansas, Florida and Medicare Advantage exemptions added ● Review approved 06/18/12: Washington exemption added ● Review approved 02/27/12 and effective 10/01/12: Updated start and stop time language due to change in HIPAA 5010 instructions ● Biennial review approved 07/18/11 and effective 11/05/09: Background section/policy template updated; start/stop time language added; Texas, Georgia, Virginia, New Jersey and Ohio exemptions added ● Review approved 07/08/09 and effective 11/05/09: Policy combined with Anesthesia Modifiers #06-165; reimbursement formula for anesthesia calculation clarified; anesthesia modifier information added; non-reimbursement of patient status modifiers clarified; medical criteria removed; dental anesthesia benefit information removed; South Carolina medical scope of practice exemption removed; Texas and Tennessee benefit exemptions removed; Florida unit rounding clarified; Georgia unit

	<p>rounding and patient status modifier exemption added; obstetrical epidural anesthesia limit added; Background section/policy template updated; references to Modifier Usage #06-066 and Modifier 23 Unusual Anesthesia #07-021 policies added</p> <ul style="list-style-type: none"> • Update due to regulatory directive (Committee Approval not required in accordance with Reimbursement Policy Program Guidelines, policy #05-017): <ul style="list-style-type: none"> ○ 10/15/08 to add South Carolina exemption • Initial committee approval 05/30/07 with effective date of 07/01/07
References and Research Materials	<p>This policy has been developed through consideration of the following:</p> <ul style="list-style-type: none"> • CMS • State Medicaid • Amerigroup state contracts ▪ American Society of Anesthesiologists • Optum Learning: Understanding Modifiers, 2016 edition
Definitions	<ul style="list-style-type: none"> • Anesthesia: Refers to the drugs or substances that cause a loss of consciousness or sensitivity to pain • Base unit: The relative value unit associated with each anesthesia procedure code as assigned by CMS • Time unit: An increment of fifteen (15) minutes where each 15-minute increment constitutes one (1) time unit • Conversion factor: A geographic-specific amount that varies by the locality where the anesthesia is administered • Reimbursement Policy Definitions
Related Policies	<ul style="list-style-type: none"> • Modifier Usage • Scope of Practice • Reduced and Discontinued Services • Maternity Services
Related Materials	<ul style="list-style-type: none"> • None