

SECTION 3

ANESTHESIOLOGY

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1 GENERAL POLICY

All anesthesiologists or certified registered nurse anesthetists (CRNA) licensed to practice in the State of Utah are eligible to participate, providing they are duly licensed and a participant in Medicare and/or Medicaid. All physicians must be enrolled with the state agency as a Medicaid Provider.

Medicaid covers anesthesia only when administered by a licensed anesthesiologist or a certified registered nurse anesthetist (CRNA) who remains in attendance for the sole purpose of rendering general anesthesia in order to afford the patient anesthesia care deemed optimal during any procedure. The base code for the anesthesia is paid once and therefore if the CRNA fills in for the initial anesthesiologist, the time for the procedure is paid but a second base for the code is not paid.

The American Society of Anesthesiologists relative value guide is accepted as the basis for coding and definition of anesthesia provided to Medicaid patients.

1 - 1 Clients Enrolled in a Managed Care Plan

A Medicaid client enrolled in a managed health care plan must receive all health care services through that plan. Refer to SECTION 1, General Information, Chapter 5, Verifying Eligibility, for information about how to verify a client's enrollment in a plan. For more information about managed health care plans, please refer to SECTION 1, Chapter 4, Managed Care Plans. Each plan may offer more benefits and/or fewer restrictions than the Medicaid scope of benefits explained in the section of the provider manual. Each plan specifies services which are covered, those which require prior authorization, the process to request authorization and the conditions for authorization.

All questions concerning services covered by or payment from a managed care plan must be directed to the appropriate plan. Medicaid does NOT process prior authorization requests for services to be provided to a Medicaid client who is enrolled in a capitated managed care plan when the services are included in the contract with the plan. Providers requesting prior authorization for services for a client enrolled in a managed care plan will be referred to that plan.

A list of MCP's with which Medicaid has a contract to provide health care services is included as an attachment to the provider manual. Please note that Medicaid staff make every effort to provide complete and accurate information on all inquiries as to a client's enrollment in a managed care plan. Because eligibility information as to what plan the patient must use is available to providers, a "fee-for-service" claim will not be paid even when information is given in error by Medicaid staff.

1 - 2 Clients NOT Enrolled in a Managed Care Plan (Fee-for-Service Clients)

Medicaid clients who are *not* enrolled in a managed care plan may receive services from any provider who accepts Medicaid. This provider manual explains the conditions of coverage for Medicaid fee-for-service clients.

2 BILLING

Anesthesia services may be billed either through the electronic data exchange or on a CMS-1500 (08/05) claim form. Refer to billing instructions in SECTION 1, Chapter 11 - 9, Billing Medicaid.

2 - 1 Specific Instructions for Anesthesia Billing *(Updated 7/1/15)*

- A. Anesthesia providers billing ASA procedure codes electronically are reminded to report anesthesia time in minutes. Enter total time in minutes in the “minutes” field. Please verify that the correct MJ qualifier is being output by your software program. To report units, the qualifier is UN. UHIN Standard #1 requires that anesthesia time be reported in minutes instead of units.

Anesthesia providers billing ASA procedure codes on paper claim forms are reminded to report the anesthesia time in minutes. Enter the number of minutes in Box 24G of the CMS-1500 (08/05) form by putting an “M” before the number for the minutes. Example: M531 in Box 24G.

If an ASA procedure is submitted without minutes or the correct MJ qualifier, Medicaid will pay one time unit, i.e., 12 minutes or less.

Postoperative pain management using code 01996 is an exception to the instructions listed above. Units will be attached to this code but no time payment is made. Submit claims with a UN qualifier indicating units, a single unit per date of service, and a “P” modifier (physical status). There will be no additional payment related to the physical status of the patient. The code describes a daily pain management service and code 01996 is reimbursed beginning the day following surgery. There is only one exception to this policy, refer to the Limitations Section 9 - B.3 in the Physician Manual.

Ambulatory surgical centers (ASC) billing for dental services shall use code 41899. Prior authorization is not required for EPSDT-eligible clients. **This is not applicable for third molar removal.** Anesthesia providers directly rendering services should bill CPT code 00170.

Obstetrical anesthesia is an exception to Medicaid’s policy concerning multiple procedures performed during a single anesthetic administration. Refer to Section 3 Anesthesiology; Chapter 4, Multiple Procedures in the Physician Manual. Providers billing for anesthesia related to delivery are reminded that for neuraxial analgesia/anesthesia for planned vaginal delivery which becomes a Cesarean delivery, the code 01967 should be used to begin the procedure. When C-Section is imminent, discontinue use of 01967 and change to code 01968. Continue on with straight time as for general surgery, reporting minutes for each anesthesia code. Procedure codes 01968 and 01969 are add-on codes which must always be submitted with the primary code 01967. These codes will not be reimbursed when billed as the only procedure code.

- B. Diagnosis: A specific diagnosis code must be used. The code 00840 used for intraabdominal procedures may deny without diagnoses clearly indicating the procedure is not for sterilization.

3 REIMBURSEMENT FOR ANESTHESIA

Anesthesia is a global service just as the surgical procedure for which it is given. No pre or postoperative services will be recognized for separate payment, including those for:

- a. For pain management on the same day as C-section, see section 3-6 and 9-1, Post-Operative Pain management Policy.
- b. The code 95955, electroencephalogram (EEG) during non-intra cranial surgery, may be used for BSI. Bispectral index monitoring (BSI) is used by anesthesia to monitor the level of anesthesia which will reduce the risk of patient awareness. The code 95812 and code 95822 may also be used to provide EEG monitoring. Routine monitoring, including EEG monitoring is included within the primary anesthesia and not reimbursed separately. Neurological monitoring is considered included within neuroanesthesia procedures. Code 95925, 95926, 95927, 95928, 95929, 95930 and 959327 will produce an incidental denial in the editing program with anesthesia services that may warrant this type of monitoring.
- c. Laryngoscopy codes 31505, 31515, and 31527 are incidental or included within the anesthesia time.

Information System (MMIS) calculates anesthesia reimbursement by adding Basic Value, plus Modifying Units (if any), plus Time Units and multiplying the total number of “anesthesia values” by a dollar conversion factor.

The Basic Value assigned to the anesthesia code includes the pre-operative and post-operative care. Medicaid does not reimburse for two Basic values on the same date of service. When a patient has to return to surgery on the same date for complications, the provider is instructed to add the additional time required for the second surgery to the primary anesthesia code.

3 - 1 Rural Services

Services performed in rural areas will be reimbursed at 12% higher than the regular fee for anesthesia . The higher fee is available only when the anesthesia services are performed in a rural setting. Payment is not based on patient residence.

3 - 2 Basic Value

A **Basic Value** is assigned for anesthetic management of most surgical procedures and is related to the complexity of the procedure. This basic value includes all usual anesthesia except the time actually spent in anesthesia care and any modifiers. The usual anesthesia included in the Basic Value are the usual pre-operative and postoperative visits, the administration of fluids and/or blood products incident to the anesthesia care and interpretation of non-invasive monitoring.

In computing payment for anesthesia, basic value units for anesthesia procedure codes are “hard coded” in Medicaid’s computer system and are obtained automatically, and do not require any additional billing requirements, other than their “identification” on the claim.

3 - 3 Time Reporting

Time Units will be added to the basic value and modifying units as is customary in the local area. Anesthesia time begins when the anesthesiologist begins to prepare the patient for the induction of

anesthesia in the operating room or in an equivalent area and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under postoperative supervision.

3 - 4 Utah Medicaid's Time Reporting Policy

Time reporting for Utah Medicaid is computed at the rate of one time unit for each twelve-minute_or fraction thereof. Fractions of time are always rounded up to the next full number.

Example: 60 minutes = 5 time units Time will be calculated as 5 time units
65 minutes = 5.42 time units Time will be calculated as 6 time units

3 - 5 Obstetrical Anesthesia - Time Reporting

Because obstetrical anesthesia is unique and an anesthesiologist may attend more than one patient concurrently under continuous regional anesthesia, there is a reduction in the unit value after the first hour of anesthesia time. For the first hour, 5 time units will be calculated; for the second hour, 2.5 units; for the third and each succeeding hour of anesthesia, 1.25 units. The reduction in unit value will affect the following ASA procedure code:

01967 Neuraxial labor analgesia/anesthesia for planned vaginal delivery

When billing obstetrical anesthesia, indicate total time, in minutes. The Medicaid Management Information System (MMIS) will calculate the appropriate reduction in unit value.

3 - 6 Post Operative Pain Management following C-Section

Effective for dates of service on or after July 1, 2002, post partum pain management provided by anesthesiologists is not a separate reimbursable service on the same day as a C-section delivery. It is considered part of the anesthesia service when an epidural catheter is in place. A bolus dose of a selected pain medication can be administered through the existing catheter before the patient is released to post-operative care, but no extra time or units will be covered.

Codes 62310 and 62311 are not appropriate for this administration and will not be covered in conjunction with obstetrical anesthesia.

In some circumstances, pain management services extend to the day following the C-section. In such cases, coverage will be provided, consistent with the Post Operative Pain Management Policy, through use of the following code:

01996 daily follow-up and management of epidural analgesia

4 MULTIPLE PROCEDURES

When multiple procedures are performed during a single anesthetic administration, Medicaid's policy is to pay the basic value for only one anesthesia procedure. It is suggested that providers select the ASA procedure code with the highest basic value. Obstetrical anesthesia is an exception to this policy.

4 - 1 Multiple Obstetrical Procedures

For dates of service on or after January 1, 2002, anesthesia for multiple obstetrical procedures may be paid the basic values for both procedures in the following circumstances:

- Neuraxial analgesia/anesthesia for planned vaginal delivery which becomes a Cesarean delivery. Code 01967 to begin the procedure. When C-section is imminent, discontinue use of 01967 and change to ---Code 01968 and continue on with straight time as for a general surgery.
- Neuraxial analgesia/anesthesia for planned vaginal delivery followed by tubal ligation on same or the next day following delivery.
 Code 01967 for deliveryCode 00851 (new code) Intraperitoneal Lower Abdomen, Tubal Ligation/Transection.

There may be other combinations of procedures which occur occasionally and will need to be reviewed for adjudication.

5 ANESTHESIA MODIFIERS

Report all anesthesia with the anesthesia five-digit procedure code (00100 through 01999) plus the addition of a physical status modifier. The use of other optional modifiers may be appropriate.

5 - 1 Physical Status Modifiers

Physical Status modifiers various levels of complexity of the anesthesia service provided. The Utah Medicaid values for physical status are as follows:

Modifier	Description	Medicaid Unit Value
P1	A normal healthy patient	0
P2	A patient with mild systemic disease	1
P3	A patient with severe systemic disease	3
P4	A patient with severe systemic disease that is a constant threat to life	4
P5	A moribund patient who is not expected to survive without the operation	6
P6	A declared brain-dead patient whose organs are being removed for donor purpose	Not Payable

When billing for anesthesia, indicate the appropriate physical status modifier. If no physical status is indicated, the Medicaid Management Information System (MMIS) assumes the physical status is P1 - a normal healthy patient. If a Physical Status Modifier is billed, MMIS automatically calculates additional payment. Utah Medicaid has not required the use of the “*unique*” *Utah Medicaid Modifier 30* since February 1, 1995. However, if this modifier is billed, MMIS will accept 30 as a valid modifier

5 – 2 Anesthesia Where Modifying Units Are Not Applicable

- General consultation, limited

- General consultation, comprehensive
- Convulsive therapy with anesthesia
- Cardiopulmonary resuscitation
- Respirator care, consultation and therapy
- Intensive care of acutely ill patient (while anesthesiologist is in personal attendance)
- Daily visits (follow-up acutely ill, maximum two days)
- Psychotherapy, verbal, drug augmented or other methods
- Electrical cardioversion
- Nerve blocks as listed

5 - 3 Other Modifiers

Under certain circumstances, medical service and procedures may need to be further modified. Other modifiers commonly used are:

- 22 Unusual Procedural Services
- 23 Unusual Anesthesia
- 51 Multiple Procedures
- 53 Discontinued Procedure
- 59 Distinct Procedural Service
 - Modifier 59 subset modifiers (X{EPSU})
 - 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

For further modifier 59 and subset information, refer to the Physician Services Utah Medicaid Provider Manual, Limitations, # E. <https://medicaid.utah.gov>, Medicaid Provider Manual.

6 SPECIAL REPORT

A service that is rarely provided, unusual, variable, or new may require a special report in determining medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure; and the time, effort, and equipment necessary to provide the service. Additional items which may be included are:

- complexity of symptoms
- final diagnosis
- pertinent physical findings
- diagnostic and therapeutic procedures
- concurrent problems
- follow-up care

7 QUALIFYING CIRCUMSTANCES

Effective October 2004, Medicaid follows the correct coding initiatives of Medicare. Medicare considers these codes B status or bundled codes. The anesthesia of special circumstance (i.e. code 99100, 99116, 99135, 99140) is figured into the complexity status of the patient (physical status modifiers), the RVU of the procedure, and the time required for the procedure. Therefore, the special circumstance codes are not reimbursed separately.

8 PRIOR AUTHORIZATION

Anesthesiologists are not required to request prior authorization (PA) from Medicaid. However, for any anesthesia code on the list titled, Medical and Surgical Procedures CPT Codes Which Require Prior Authorization, included in this section, the anesthesiologist is required to obtain the PA number for the CPT code from the surgeon and enter the PA number on the claim when billing for anesthesia.

1. The surgeon must obtain prior authorization (PA) when required for procedures identified in the Medical and Surgical Procedures List included with this manual. For information about the prior authorization process, refer to SECTION 1, General Information, Chapter 9, Prior Authorization Process. Procedures which require PA include, but are not limited to cosmetic, hysterectomy, sterilization, and abortion. Medicaid staff review each request to ensure that all federal and state requirements are met. If so, staff assigns a PA number for the CPT procedure and enters the PA number and appropriate anesthesia code into Medicaid's computer system.
2. When an anesthesiologist bills for an ASA code associated with a CPT procedure code which requires prior authorization, the claim may be paid only if the surgeon obtained prior authorization for the procedure. If the surgeon did not obtain a prior authorization, Medicaid cannot reimburse either the surgeon or the anesthesiologist. This applies to codes such as 00851 where the code itself describes a sterilization procedure.

Anesthesia CPT codes, which may require prior authorization, are considered approved when approval for surgery is provided. A list of codes requiring prior authorization or manual review can be accessed at: <http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php>.

The following list of anesthesia codes have limitations or special instructions:

- 00104 Anesthesia for electroconvulsive therapy. Prior authorization is required through the contracted mental health program.
- 00402 Anesthesia for reconstructive breast procedures (reduction, augmentation, muscle flaps). The prior approval written for the surgery includes the anesthesia approval.
- 00840 Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified. This code includes many procedures which do not require prior authorization. This code cannot be used for any procedure related to sterilization, code 00851 must be used. In circumstances where the procedure may be with an unlisted procedure, non-covered procedure, or cosmetic procedure, the anesthesia should be manually reviewed for payment (e.g., Panniculectomy). The prior approval written for surgery includes the anesthesia approval.
- 00851 Anesthesia for intraperitoneal procedures in lower abdomen, including laparoscopy; tubal ligation. The prior approval written for the surgery includes the anesthesia approval.

- 00921 Anesthesia for vasectomy. The prior approval written for the surgery includes the anesthesia approval.
- 00952 Anesthesia for hysteroscopy and/or hysterosalpingography. **PRIOR APPROVAL:** Written. Covered when the primary surgery receives prior authorization (e.g., code 58565) or the hysteroscopy does not require prior authorization. Non-covered for hysterosalpingography related to infertility.
- 01966 Anesthesia for induced abortion procedures. The prior approval written for the surgery includes the anesthesia approval.

3. Exceptions to the prior authorization requirement can only be considered under one of the following circumstances:
 - a. The procedure was performed in a life-threatening or justifiable emergency situation.
 - b. Medicaid is responsible for the delay in approval.
 - c. The patient is retroactively eligible for Medicaid. Refer to SECTION 1, General Information, Chapter 9 - 7, Retroactive Authorization.

Approval for services related to these exceptions may be granted "after-the-fact" with appropriate documentation and review. If approved, the associated ASA code may also be reimbursed.

For more information about prior authorization, call Medicaid Information.

In the Salt Lake City area, call **801-538-6155**. Call toll free in Utah and the surrounding states of Arizona, New Mexico, Nevada, Idaho, Wyoming and Colorado: **1-800-662-9651**.

Follow the telephone menu prompts for a Medicaid Provider, then for Prior Authorization Unit, then for sterilizations.

9 LIMITATIONS

9 - 1 Postoperative Pain Management and Palliative Therapy

Effective for services provided on or after July 1, 2001, postoperative pain management and selective palliative therapy provided by anesthesiologists are covered Medicaid services. Pain management must be related to the immediate post operative period or a catastrophic or terminal illness where palliative therapy is indicated. The Primary Care Physician or surgeon must request or order pain services to be provided by an anesthesiologist. Prior authorization is not required.

Specific conditions for coverage are described below.

A. Definitions

- **Epidural Analgesia** means placement of an epidural catheter, injection of anesthetic or therapeutic substances, and daily management of drug therapy.
- **Nerve Block** or single epidural injection is used to treat acute pain. Often pain management provided in this manner provides an opportunity to treat the pain more effectively, improves pain management.

- **Pain Relief** is reduction of the level of pain, not elimination of pain.
- **Palliative Therapy** means therapy that relieves symptoms of illness or a disorder but does not promote a cure. An example of palliative therapy is treatment for terminal illness or complex medical problems where severe pain is a significant factor.
- **Patient Controlled Analgesia (PCA)** means intravenous placement of a catheter for self-administration of therapeutic drugs through an infusion device. PCA includes daily management and follow-up services by the anesthesiologist, related to the drug therapy.

B. Epidural analgesia may be provided by single injection or continuous infusion. Sometimes placement of an epidural catheter prior to surgery is preferred because the patient can report any accompanying paresthesias and the catheter can be tested prior to surgery.

Medicaid will pay for an epidural or peripheral nerve block injection for postoperative pain management in patients receiving general anesthesia, spinal (subarachnoid injection) anesthesia, or regional anesthesia by epidural injection as described above, and may be administered preoperatively, intraoperatively, or postoperatively. Placement of the PCA infusion set up will occur in the recovery room following surgery.

1. Submit the claim for initiation of postoperative pain management services on a CMS-1500 (08/05) claim form separate from the general anesthesia claim. The same date of service as the anesthesia administration may be used. Submit documentation of the primary anesthesia record, with documentation related to the injection service for postoperative pain management, for review.
2. Submit a claim for postoperative, daily pain management (code 01996) as of the day following placement of the catheter or set up of the PCA. Submit a CMS-1500 (08/05) claim separate from the anesthesia for the surgical procedure, and separate from the charge for initial placement of epidural or set-up of PCA charge. Use CPT or ASA codes on the claim, depending on the route of administration. No other codes will be accepted. There is one exception to the payment of code 01996 on the same date as the primary anesthesia procedure.
3. Sometimes the epidural catheter for postoperative pain management may be placed at the time of surgery by the surgeon because he/she is operating on the back. This will occur only in laminectomy or decompression (CPT codes 63001-63290) and spinal lesion or deformity (CPT codes 22100-22852). Since the anesthesiologist does not place the epidural catheter but does manage the catheter and medication administration the day of surgery, a daily visit code (01996) will be allowed in addition to the general anesthesia on the day of surgery. The catheter is left in place for three days or less because the patient usually has recovered sufficiently to allow removal. Documentation must support daily pain management code 01996. For reimbursement of postoperative pain management, the postoperative injection or epidural service must be submitted with modifier 59* or a subset modifier. The time of placement of the epidural catheter or block injection must be clearly documented in the medical record. Failure to document the services, to indicate the procedure was completed, will result in a denial of reimbursement for service.

*For further modifier 59 subset information refer to 5 - 3 Other Modifiers, in this manual.

4. Anesthesia service such as code 00630 delivered for chronic pain management is a non-covered service. The primary anesthesia code 00630 and a series of block, epidural, and/or trigger point injections for chronic pain management are not payable on the same date of service. Chronic pain management coverage and limitations for trigger point and epidural block injections are described in Section 2. Refer to the *Physician Provider Manual*.

C. Use the approved postoperative pain management codes listed below. Submit a CMS-1500 (08/05) claim separate from the general anesthesia claim.

1. Epidural or Nerve Block Analgesia by continuous infusion

- *62318 Injection, including catheter placement, continuous infusion or intermittent bolus, of therapeutic substances, epidural or subarachnoid; cervical or thoracic.
- *62319 Injection, including catheter placement, continuous infusion or intermittent bolus, of therapeutic substances; lumbar, sacral (caudal).
- *64416 Injection, anesthetic agent plexus, continuous infusion by catheter
- *64446 Injection, anesthetic agent, sciatic nerve, continuous infusion by catheter
- *64448 Injection, anesthetic agent, sciatic nerve, continuous infusion by catheter

*Select one of these codes for neuraxial narcotic injections or placement of the catheter when the service is not part of the general anesthetic. Payment will be made only once during an episode of care. Reimbursement for post-operative daily pain management is:

- 01996 Daily follow-up and management of epidural or nerve block analgesia by continuous or intermittent infusion. Units will be attached to this code but no time. (A "0" is not an appropriate unit to use in this field.) Payment will be made only once daily beginning **the day after** the surgical procedure unless the epidural catheter has been placed by the surgeon, see B.2 above.

2. Epidural or Nerve Block Analgesia by Single injection

- *62310 Injection, single (not via indwelling catheter) not including neurolytic substances, with or without contrast, epidural or subarachnoid; cervical or thoracic.
- *62311 Injection, single (not via indwelling catheter) not including neurolytic substances, with or without contrast, epidural or subarachnoid, lumbar, sacral (caudal)
- *64415 Injection, anesthetic agent, brachial plexus, single
- *64417 Injection, anesthetic agent; axillary nerve, single
- *64445 Injection, anesthetic agent; sciatic nerve, single
- *64447 Injection, anesthetic agent; femoral nerve, single
- *64450 Injection, anesthetic agent; other peripheral nerve or branch

*Select one of these codes for a single epidural or nerve block injection whose primary purpose is for postoperative pain, and unrelated to anesthesia for surgery. Payment will only be made once during an episode of care. Payment should not be denied as part of another service.

3. Patient Controlled Analgesia (PCA)

- *99231 Subsequent Hospital Care
- *99232 Subsequent Hospital Care

Select one of these codes for the initial set-up and placement of the PCA. The subsequent hospital care code at the appropriate level of service may be billed daily as long as medical record documentation supports management of the PCA.

4. Terminal Illness or Complex Medical Problem Management

Pain management for a terminal illness or complex medical problem become very individualized and dependent on the condition and needs of the patient. For the terminally ill, palliative care for comfort may be the major need. As always, such care can be provided through the primary care physician and family assistance, through appropriate home health service or as part of an inpatient admission for general treatment or terminal care of the medical condition. The primary care physician remains ultimately responsible, but when the patient's condition reaches the point that assistance is needed, the primary care physician can provide orders or referral to a pain management specialist who can use this protocol to place lines and provide daily management of the necessary medications.

10 CODES COVERED FOR PROVIDER TYPE 38, CRNA

A list of codes can be accessed at: <http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php>.

See Section 8 – **Prior Authorization** in this manual for codes with special instructions (e.g., 00104, 00840, and 00952).

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