Section 3

Anesthesiology

Table of Contents

1 General Information 2
1-1 General Policy 2
1-2 Fee-For-Service or Managed Care 2
1-3 Definitions 2
2 Provider Participation Requirements 3
3 Member Eligibility 3
4 Coverage and Limitations - Postoperative Pain Management and Palliative Therapy 3
5 Non-Covered Services 4
6 Prior Authorization 4
7 Billing 4
8 References 6
Index 7

1 General Information

The *Utah Medicaid Provider Manual, Section 3: Anesthesiology* is designed to be used in conjunction with other sections of the *Provider Manual*, specifically *Section I: General Information* and *Section 2: Physician Services* as well as with other applicable sections and attachments. Refer to the Utah Medicaid website at https://medicaid.utah.gov.

Information in this manual represents available services when medically necessary. Services may be more limited or may be expanded if the proposed services are medically appropriate and are more cost effective than alternative services.

1-1 General Policy

- All anesthesiologists or certified registered nurse anesthetists (CRNA) licensed to practice in the State of Utah are eligible to participate, provided they are enrolled as a Utah Medicaid provider.
- Medicaid covers anesthesia only when administered by a licensed anesthesiologist or a CRNA who remains in attendance for the sole purpose of rendering anesthesia to afford the patient anesthesia care most conducive to favorable outcomes.
- Medicaid follows the National Correct Coding Initiative (NCCI).

1-2 Fee-For-Service or Managed Care

This manual provides information regarding Medicaid policy and procedures for fee-for-service Medicaid members and for carve-out anesthesia services provided to members enrolled in an applicable Managed Care Organization (MCO). Refer to *Section I: General Information* for information regarding Managed Care Organizations (MCOs) and how to verify if a Medicaid member is enrolled in an MCO. Medicaid members not enrolled in an MCO and not enrolled in Division of Medicaid and Health Financing (DMHF) Restriction Program, may receive services from any qualified provider who accepts Medicaid.

1-3 Definitions

Definitions of terms used in other Medicaid programs are available in the provider manual *Section I: General Information*. Definitions specific to the content of this manual include:

American Society of Anesthesiologists (ASA)
American Society of Anesthesiologists sets the standards and guidelines for anesthesia and operative pain management.

Chronic Pain
Chronic pain is defined as pain continuing beyond six months.

CPT
Current Procedural Terminology (Professional Edition)

Episode of Care
CMS defines an episode of care as the set of services provided to treat a clinical condition or procedure.

Pain Management
The process of providing medical care that alleviates or reduces pain.

Palliative Therapy
Comfort care which includes pain management and treatment of side effects in a patient with serious or terminal illness.

2 Provider Participation Requirements

Refer to *Section I: General Information* for provider enrollment information.

3 Member Eligibility

A Medicaid member is required to present the Medicaid Identification Card before each service. It is the responsibility of the provider to verify the member's eligibility each time before service is rendered. Possession of a Medicaid Member Card does not guarantee eligibility, because eligibility and health plan enrollment may change month-to-month. To verify member eligibility use one of these tools: AccessNow, Eligibility Lookup Tool, or ANSI 270 and ANSI 276. For a brief description of each resource and for more information regarding eligibility refer to *Section I: General Information* (https://medicaid.utah.gov).

4 Coverage and Limitations - Postoperative Pain Management and Palliative Therapy

Medicaid covers with limitations, post-operative pain management and selective palliative therapy services provided by an anesthesiologist and ordered by the treating physician or surgeon.

- Pain management must be related to the immediate post-operative period.
- Pain management by the surgeon is part of the global surgical service.
- Palliative therapy must be related to a serious or terminal illness.

Postoperative pain management services may begin preoperatively, intraoperatively, or postoperatively.

A. Nerve block or single epidural injection
   - Nerve block(s) or single epidural analgesia whose primary purpose is for postoperative pain, and unrelated to anesthesia for surgery should be reported only once during an episode of care.
   - Report postoperative block injection(s) or epidural injection by appending the appropriate X subset of modifier 59. Start and stop time of block injection must be clearly documented in the medical record.
   - Outpatient chronic pain management coverage and limitations are described in *Section 2, Physician Services*.

B. Nerve block or epidural analgesia by continuous infusion
   - Anesthesia time includes the Patient Controlled Analgesia (PCA) infusion set up in the recovery room.
   - Placement of a catheter should be reported only once.

C. Daily pain management

- Report CPT 01996, daily pain management, **on the day of** the procedure when an epidural catheter is placed by the surgeon.
- Report CPT 01996, daily pain management, **on the day after** placement of an epidural catheter by the anesthesiologist.
- Report appropriate subsequent hospital E/M level when the patient is transitioning from the PCA pump and IV medications are still being used.
- Daily pain management and subsequent hospital care codes will not be reimbursed on the same date of service.

5 Non-Covered Services

Certain specific non-covered services are listed below. The list is not all inclusive.

Medicaid does not cover:

- Inpatient hospitalization for the sole purpose of chronic pain management.
- Surgical procedures for the reversal of previous elective sterilization, both male and female.
- Experimental or medically unproven physician services or procedures.
- Cosmetic, plastic, or reconstructive surgery procedures, unless determined medically necessary.

Medicaid reimbursement for abortion services is limited; refer to *Section I: General Information* for requirements and coverage and reimbursement.

6 Prior Authorization

Prior authorization (PA) is required for certain anesthesia services. Providers must determine if a PA is necessary before providing services. Failure to obtain a PA may result in payment denial by Medicaid. The surgeon is expected to obtain prior authorization for all codes with a prior authorization requirement. When PA is issued for a procedure that requires authorization, associated anesthesia codes that also require authorization are added to the PA.

When an anesthesia provider bills for an ASA code associated with a CPT procedure code which requires prior authorization, the claim must include the prior authorization number issued to the surgeon. If the surgeon did not obtain a prior authorization, the anesthesia provider may request prior authorization retroactively. The anesthesia provider should submit a completed PA Request Form, the operative report, and any applicable consent forms required by Utah Medicaid. Authorization is not issued for any services in conflict with federal or state law, Medicaid policy, or for procedures in which prior authorization was requested and denied.

General prior authorization information is in *Section I: General Information*. Code specific coverage and prior authorization requirements are on the Medicaid website Coverage and Reimbursement Lookup Tool at: http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

7 Billing

Refer to *Section I: General Information* for detailed billing instructions.

Anesthesia entails pre-anesthesia evaluation, intraoperative, and post-anesthesia care. It includes all services associated with the administration and monitoring of the anesthetic/analgesic care (MAC).

A. Anesthesia Time Reporting
Report anesthesia time in minutes whether reporting electronically or on a paper claim form.

- Electronic claims
  Enter total time in minutes in the "minutes" field with the correct MJ (anesthesia minutes) qualifier.

- Paper claim forms
  CMS-1500 (2/12) form
    a. Enter the minutes in Box 24G.
    b. Put an "M" before the minutes.
       Example: M531.

  If a claim is submitted without minutes or the correct MJ qualifier, Medicaid pays one time unit, i.e., 12 minutes or less.

B. Obstetrical Anesthesia - Time Reporting
Obstetrical neuraxial anesthesia for planned vaginal delivery is unique in that the 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. Example: For the first hour, 5 time units is calculated; for the second hour, 2.5 units; for the third and each succeeding hour of anesthesia, 1.25 units.

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

C. Daily Pain Management
Daily pain management (01966) is a 24 hour service code, due to system limitations one time unit should be reported.

D. Dental Services
Ambulatory Surgical Centers (ASC) and outpatient hospitals report dental services using CPT 41899. Anesthesia providers directly rendering services should bill CPT 00170. For coverage details, refer to *Section 2: Dental, Oral Maxillofacial, and Orthodontia Services Provider Manual* at https://medicaid.utah.gov/ and the Coverage and Reimbursement Lookup tool at http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

E. Procedure Codes
Anesthesia procedure codes with accompanying criteria and limitations are found on the Medicaid website Coverage and Reimbursement Lookup Tool http://health.utah.gov/medicaid/stplan/lookup/CoverageLookup.php.

F. Conscious Sedation
When a procedure that normally uses conscious sedation requires general anesthesia, a supportive diagnosis is required. Diagnoses supporting the need for general anesthesia in place of conscious

sedation should be reported for conditions such as cognitive dysfunction, intoxication, psychological impairment, or movement disorders.

G. Anesthesia Modifiers
Report all anesthesia services with the anesthesia CPT codes plus the physical status modifier. The use of other optional modifiers may be appropriate.

1. Physical Status Modifiers
Physical Status modifiers vary in levels of complexity of the anesthesia service provided. If no physical status modifier is reported, the modifier indicating a normal healthy patient is used in adjudication. Medicaid does not pay an additional value for P1 or P5 status codes.

2. Additional Anesthesia Modifiers
23 Unusual Anesthesia
24 Unrelated Evaluation and Management Service
53 Discontinued Procedure
59 Distinct Procedural Service
Modifier 59 subset modifiers
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

8 References

Professional Edition of Current Procedural Terminology, American Medical Association.

HCPCS Level II, AAPC, OptumInsight, Inc., current edition

R414-10-5. Service Coverage.

State Plan Amendment,

Attachment, 4.19-A, Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care
Attachment, 4.19-B, Methods and Standards for Establishing Payment Rates - Other Types of Care
Attachment 4.19-B, Physician Services 42 CFR 447.405 Amount of Minimum Payment, E. Anesthesiologist/Anesthetist

Public Health. 42 CFR 414.46, Additional rules for payment of anesthesia services

Index

Ambulatory Surgical Centers 5
Anesthesia Modifiers 6
anesthesiologists 2
Billing 5
certified registered nurse anesthetists 2
chronic pain 4
chronic pain management 3
claims 5
Conscious Sedation 6
CRNA 2
Daily pain management 4, 5
Dental Services 5
Division of Medicaid and Health Financing 2
eligibility 3
epidural 3
  continuous infusion 4
  single injection 3
Inpatient hospitalization 4
Managed Care Organization 2
Medicaid Identification Card 3
medically necessary 2
modifier 59 3
Nerve block 3, 4
Obstetrical anesthesia 5
Obstetrical Anesthesia - Time Reporting 5
palliative therapy 3
Patient Controlled Analgesia 4
PCA 4
Physical Status Modifiers 6
post-operative pain management 3
Procedure Codes 6
Restriction Program 2
Section I: General Information 2, 3
terminal illness 3