38 Anesthesiology

Administration of anesthesia is a covered service when administered by or directed by a duly licensed physician for a medical procedure that is covered by Medicaid.

The policy provisions for anesthesia can be found in the Alabama Medicaid Agency Administrative Code, Chapter 6.

38.1 Enrollment

HPE enrolls anesthesiologists, Certified Registered Nurse Anesthetists (CRNA) and Anesthesiology Assistants (AA) and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the Alabama Medicaid Agency Administrative Code, and the Alabama Medicaid Provider Manual.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

HPE also enrolls Certified Registered Nurse Anesthetists (CRNA), and Anesthesiology Assistants (AA) who are employed by a Medicaid enrolled physician or hospital.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as an anesthesiologist, CRNA, or AA provider is added to the Medicaid systems with the NPIs provided at the time application is made. Appropriate specialty codes are assigned to enable the provider to submit requests and receive reimbursements for anesthesia-related claims.

NOTE:
The 10-digit NPI is required when filing a claim.

Anesthesiologists are assigned a provider type of 31 (Physician). CRNAs are assigned a provider type of 09. AAs are assigned a provider type 10 Valid specialties for the above include the following

- Anesthesiology Assistant (101)
- CRNA (094)

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Enrollment Policy for Anesthesiology Providers

Providers (in-state and out-of-state) who meet enrollment requirements are eligible to participate in the Alabama Medicaid Program.

In addition to the completed application, the following information for Anesthesiologist Assistants and CRNAs must be submitted and approved before the enrollment process can be initiated:

- Copy of current state license
- Copy of current certifications (CRNA or AA)

38.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations. Refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for general criteria on Medical Necessity/ Medically Necessary Care.

Administration of anesthesia is a covered service when administered by or directed by a duly licensed physician for a medical procedure that is covered by Medicaid. Medical direction by an anesthesiologist of more than four Certified Registered Nurse Anesthetists (CRNAs) or Anesthesiology Assistants (AAs) concurrently will not be covered.

Administration of anesthesia by an AA is a covered service when the AA has met the qualifications and standards set forth in the Alabama Board of Medical Examiners. The AA must enroll and receive a NPI to bill the Alabama Medicaid Program. Reimbursement shall be made only when the AA performs the administration of anesthesia under the direct medical supervision of the anesthesiologist

Administration of anesthesia by a self-employed CRNA is a covered service when the CRNA has met the qualifications and standards set forth in Rule No. 610-X-9-.01 through 610-X-9-.04 of the Alabama Board of Nursing Administrative Code. The CRNA must enroll with a valid NPI to bill under the Alabama Medicaid Program. When billing for anesthesia services, providers shall follow the guidelines set forth in the current Relative Value Guide published by the American Society of Anesthesiologists for basic value and time units.

For billing purposes, anesthesia services rendered with medical direction for one CRNA or AA is considered a service performed by the anesthesiologist. The definition of medical direction is an anesthesiologist medically directing four concurrent cases (CRNA/AA) or less. In order to bill for medical direction, the anesthesiologist must be immediately physically available at all times. Addressing an emergency of short duration, or rendering the requisite CRNA or AA direction activities (listed below in a. through g.), within the immediate operating suite is acceptable as long as it does not substantially diminish the scope of the supervising anesthesiologist's control. If a situation occurs which necessitates the anesthesiologist’s personal continuing involvement in a particular case, medical direction ceases to be available in all other cases.

In order for the anesthesiologist to be reimbursed for medical direction activities of the CRNA or AA, the anesthesiologist must document the performance of the following activities:

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- Performs a pre-anesthesia examination and evaluation
- Prescribes the anesthesia plan
- Personally participates in the most demanding procedures in the anesthesia plan, including induction as needed, and emergencies
- Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual
- Monitors the course of anesthesia administration at frequent intervals
- Remains immediately physically available for immediate diagnosis and treatment of emergencies
- Provides indicated post-anesthesia care

A necessary task or medical procedure may be executed while concurrently medically directing CRNAs or AAs only if the task or procedure is one which may be: (1) immediately interruptible without compromising the wellbeing, quality of care, or health of the recipient and (2) is executed in an area close enough to the operating rooms where the CRNAs and AAs are being medically directed and that will permit the physician to remain in compliance with the requirements of being immediately physically available. Examples of an “area close enough to the operating rooms” are the Post-Anesthesia Care Unit (PACU) or receiving room. A task or procedure that may be stopped instantly is defined as one of limited difficulty and brief duration so that if it is stopped instantly, it would not interfere with the quality of care, wellbeing, or health of the recipient. There are two exceptions to the above:

1. Acting in response to urgencies of short duration or medical emergencies (e.g., ACLS provision, intubation, starting difficult intravenous (IV) lines that without them would reduce the recipient’s quality of care, etc.)
2. Labor epidural placement and management

The execution of a trigger point injection or an epidural steroid injection while medically directing is permissible when requested by another physician. The 1:4 ratio should be maintained while the trigger point injection or the epidural steroid injection is being executed. The consult for the execution of the aforementioned may serve as the second, third, or fourth simultaneous case. Therefore the execution of these limited pain services is disallowed while medically directing four simultaneous anesthetics. The ability to respond to urgent or emergent needs in the hospital (operating room, labor and delivery room, or anywhere in the hospital where his/her responsibility lies) may not be decreased at any time and is the responsibility of the anesthesiologist who is medically directing. The intent of this exception is to allow for provision of commonly requested procedures and to improve effectiveness. However, this exception does not include consults to diagnose. Diagnosis of chronic pain and treatment of complex problems is not allowed while simultaneously medically directing CRNAs and AAs.

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Global Anesthesia Definition

The Agency has identified certain procedures to be included in the global payment for the anesthesia services. These procedures include but are not limited to the following: general anesthesia, regional anesthesia, local anesthesia, supplementation of local anesthesia, and other supportive treatment administered to maintain optimal anesthesia care deemed necessary by the anesthesiologist during the procedure.

Anesthesia services include:

- All customary preoperative and postoperative visits,
- Local anesthesia during surgery,
- The anesthesia care during the procedure,
- The administration of any fluids deemed necessary by the attending physician, and any usual monitory procedures

Interpretation of non-invasive monitoring to include EKG, temperature, blood pressure, pulse, breathing, electroencephalogram and other neurological monitoring,

Monitoring of left ventricular or valve function via transesophageal echocardiogram,

Maintenance of open airway and ventilatory measurements and monitoring,

Oximetry, capnography and mass spectrometry.

Monitoring all fluids used during cold cardioplegia through non-invasive means. Additional claims for such services should not be submitted.

Placement of lines such as arterial catheterizations and insertion and placement of pulmonary artery catheters (e.g., Swan-Ganz) for monitoring will no longer be included in the global anesthesia reimbursement when billed with other procedures but will be allowed to be billed using the same guidelines outlined in this chapter under “Special Situations for Anesthesia”. The time of placement of invasive monitors and who placed them should be documented in the medical record. Verification of anesthesia time units may be subject to post-payment audits. Billing for anesthesia time while placing invasive monitors is not allowed unless the patient required general anesthesia for placement.

The time anesthesia starts is at the beginning of induction via the injection or inhalation of an anesthetic drug or gas and ends at the time the recipient is transferred to the recovery room or post anesthesia care unit (PACU). Induction is defined as the time interval between the initial injection or inhalation of an anesthetic drug or gas until the optimum level of anesthesia is reached. The recipient must be prepared by the anesthesiologist prior to induction and must be assessed by the anesthesiologist immediately after the surgical procedure. Up to 15 minutes are allowed for the preparation of anesthesia, and up to 15 minutes are allowed after the operation (for transfer of the recipient to the receiving room, recovery room, or PACU). It is inappropriate to bill for anesthesia time while the patient is receiving blood products or antibiotics in the holding area or waiting in a holding area, or waiting in the operating room more than 15 minutes prior to induction.

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Local anesthesia is usually administered by the attending surgeon and is considered to be part of the surgical procedure being performed. Additional claims for local anesthesia by the surgeon should not be filed. Any local anesthesia administered by an attending obstetrician during delivery (i.e., pudendal block or paracervical block) is considered part of the obstetrical coverage. Additional claims for local anesthesia administered by an attending obstetrician during delivery should not be filed.

When regional anesthesia (i.e., nerve block) is administered by the attending physician during a procedure, the physician's fee for administration of the anesthesia is billed at one-half the established rate for a comparable service when performed by an anesthesiologist. When regional anesthesia is administered by the attending obstetrician during delivery (i.e., saddle block or continuous caudal), the obstetrician's fee for administration of the anesthesia will be billed at one-half the established rate for a comparable service performed by an anesthesiologist. When regional anesthesia is administered by an anesthesiologist during delivery or other procedure, the anesthesiologist's fee will be covered and should be billed separately.

When an epidural is performed as part of maternity labor/delivery by a resident, modifiers **AA** and **GC** must be billed along with the procedure code to identify the service is administered under the direction of a physician **(AA**), and performed by the resident **(GC).** When the epidural is performed by a physician in the absence of a resident, use modifier **AA** only.

When a medical procedure is a non-covered service under the Alabama Medicaid Program, the anesthesia for that procedure is also considered to be a non-covered service.

A primary anesthesia procedure is included in the procedure code range of 00100-01997 as noted in the Relative Value Guide.

NOTE:

Medical record documentation should clearly support and reflect physician services. Post-payment reviews may be performed.

Special Situations for Anesthesia

If two procedures of equal unit value are billed, the first procedure will be paid and the second one will deny because the subsequent procedure is included in the primary anesthesia charge.

If two procedures are billed with different unit values, the procedure with the greatest unit value will pay and the other procedure will deny because the subsequent procedure is included in primary anesthesia charge.

The anesthetic agent for nerve blocks (CPT codes 64400-64530) is included in the reimbursement fee for the performance or administration of the nerve block. No additional procedures should be filed for the nerve block medication.

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Anesthesia for CAT Scans or MRI/MRA Procedures is not covered for anesthesiologists. The attending/admitting physician is responsible for ordering the necessary measure(s) to ensure the patient is prepared for these tests.

Monitored Anesthesia Care is a covered service.

Medicaid does not cover physical status modifiers.

Standby anesthesia is not payable under Medicaid.

Consultations

A consultation for anesthesia performed on the day of or days before a procedure is considered part of the global procedure and is not a separately reimbursable item.

There are two exceptions to the above as outlined below.

- A recipient with chronic intractable pain receives a consult from an anesthesiologist for the chronic intractable pain, or
- A recipient receives a consult from an anesthesiologist to have an anesthesia procedure performed but ends up not receiving the anesthesia, e.g., the surgery is canceled due to complications.

Post-Operative Pain Management and Epidural Catheters

Surgeons routinely provide necessary post-operative pain management services and are reimbursed for these services through the global surgery fee. The surgeon should manage post-operative pain except under extraordinary circumstances. Procedures involving major intra-abdominal, vascular and orthopedic, and intrathoracic procedures will be covered for post-operative pain management by an anesthesiologist when medically indicated. Postoperative pain management services is not covered by non-physicians.

Under certain circumstances an anesthesia practitioner may separately report an epidural or peripheral nerve block injection or catheter for post-operative pain management when the surgeon requests assistance with post-operative pain management. A paper claim, CMS Form 1500 with supporting medical documentation must be submitted to the Alabama Medicaid Agency fiscal agent in order to be processed. Refer to the NCCI manual at www.cms.gov/Medicare/Coding/NationalCorrectCodingInitiative for specific coding details and further information.

The definition for post-operative pain management is the management of a recipient's pain beyond, or separate from, the recovery room or operating room. The separately identifiable physician-recipient encounter and management should occur outside the intraoperative area. A separately identifiable physician-recipient encounter reflecting the prescription of medication, associated monitoring, adjustment(s) of medication, and ongoing assessments for complications should be clearly reflected in the medical record documentation.

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No additional payment is allowed for an injection of Duramorph or other analgesic agents as a boost at the end of an anesthesia procedure (using the same catheter used for the epidural or spinal anesthesia) without a separately identifiable physician-recipient encounter including the prescription of medication, associated monitoring, adjustment(s) of medication, and ongoing assessments for complications. However, if there is a separately identifiable physician-recipient encounter on subsequent post-op days, where the physician provides post-operative analgesic orders and manages post-operative analgesic complications, daily management of epidural or subarachnoid drug administration may be billed.

If a recipient receives general anesthesia and consequently requires additional pain control such as an epidural injection or an epidural catheter placement on the same day as the general anesthesia, the single injection or catheter placement will be reimbursed at one-half of the allowable. However, catheter placement and daily management of an epidural catheter is not allowed on the same date of service. When the physician provides a separately identifiable physician-recipient encounter to manage and evaluate the catheter and it is reflected in the medical record, this coverage is satisfactory for a reasonable period of time over the consecutive post-operative days.

Patient Controlled Analgesia

Patient controlled analgesia (PCA) services are reimbursable when they are administered by an anesthesiologist and are performed for the control of post-operative pain. A separately identifiable physician-recipient encounter should be reflected in the medical record documentation. PCA pumps are usually administered through an intravenous (IV) line or the PCA pump is connected to an epidural catheter line.

When an anesthesiologist provides the management of the PCA pump through an IV line, the anesthesiologist will be allowed a total of four units and will be considered a global payment for the management regardless of the number of days the recipient remains on the pump. Use procedure code 96522 for daily hospital management of intravenous patient-controlled analgesia.

The anesthesiologist should use the appropriate procedure code(s) when filing claims for a single injection or for an injection including catheter placement (epidural, subarachnoid, cervical, thoracic, lumbar, or sacral) when the PCA pump is connected to an epidural line. Placement of the epidural catheter and daily management of a subarachnoid or epidural catheter is not reimbursable on the same date of service. Daily management of a subarachnoid or epidural catheter is reimbursable on subsequent days. Delivery of pain medication through intermittent injections, a regular infusion, or by a PCA pump is included in the management of an epidural line whether a registered nurse or a physician administers it. Additional units for a PCA pump that is connected to an epidural line is not separately reimbursable.

The global surgical reimbursement fee to the surgeon includes the management of a PCA pump for post-operative pain control and is not a separately reimbursable item. Similarly, a physician's global medical service reimbursement includes the management of a PCA pump for recipients with chronic pain control or terminal cancer and is not separately reimbursable.

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Intractable Pain and Epidural Catheters

Some forms of conventional therapy such as oral medication, physical therapy, or a TENS unit may not relieve recipients with intractable pain. Placement of an epidural catheter may be allowed when medically necessary for recipients with intractable pain. Reimbursement for daily management is allowed when it is medically necessary and is a separately identifiable physician-recipient encounter is clearly documented in the medical record by the anesthesiologist. Placement of an epidural catheter and daily management of an epidural catheter is not reimbursable on the same date of service.

38.3 Prior Authorization and Referral Requirements

Anesthesiology procedure codes generally do not require prior authorization. Refer to Chapter 4, Obtaining Prior Authorization, for general guidelines.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39 Patient 1st Billing Manual to determine whether your services require a referral from the Primary Medical Provider (PMP).

NOTE:

Consults performed in the inpatient hospital setting do not require a Patient 1st referral. Consults performed in a setting other than inpatient hospital require a Patient 1st referral.

38.4 Cost Sharing (Copayment)

Copayment amount does not apply to services provided by Anesthesiologists, Certified Registered Nurse Anesthetists or Anesthesiology Assistants.

38.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

Providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:

When filing a claim on paper, a CMS-1500 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare-related Claim Form.

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This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

38.5.1 Time Limit for Filing Claims

Medicaid requires all claims for Anesthesiologists, CRNAs and AAs to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

38.5.2 Diagnosis Codes

The International Classification of Diseases -10th Revision - Clinical Modification (ICD-10-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, AMA Plaza 330 North Wabash Ave, Suite 39300 Chicago, IL 60611-5885, or 1-800-621-8335.

NOTE:

ICD-9 codes should be used for claims submitted with dates of service prior to or equal to 09/30/2015.

ICD-10 codes should be used for claims submitted with dates of service on/after 10/01/2015.

NOTE:

ICD-9 or ICD-10 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits). Do not use decimal points in the diagnosis code field.

38.5.3 Procedure Codes and Modifiers

Anesthesia providers are required to utilize the appropriate anesthesia code identified in the current Relative Value Guide published by the American Society of Anesthesiologists. Time in attendance should be billed by listing **total minutes** of anesthesia time in block 24G of the CMS-1500 claim form. Type of service “7” should be used for billing anesthesia codes (00100-01997). The (837) Institutional electronic claim and the paper claim have been modified to accept up to four Procedure Code Modifiers. Effective October 1, 2004 to bill for code 90784, bill the first line item with the code and one unit. Bill the second line item with code 90784 with modifier 76 (repeat procedure) and 3 units.

HPE will calculate total units by dividing the total minutes (reported in block 24G) by 15, rounding up to the next whole number, and adding the time units to the auto-loaded base unit values. The base unit values are derived from the ASARVG for CPT-4 anesthesia codes.

Qualifying Factors

Historically, beginning on June 14, 2002, qualifying factors were reimbursable.

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However, effective July 31, 2013 qualifying factors are no longer reimbursable.

Medical Direction - CRNA or AA

Two modifiers are used to indicate whether the service was medically directed or not medically directed in regards to anesthesia. The modifiers listed below should be used:

- QX - MEDICALLY DIRECTED
- QZ - NOT MEDICALLY DIRECTED

Medical direction should only be billed when supervision of the CRNA or AA is rendered by an anesthesiologist. If a procedure is medically supervised by the surgeon, the claim should be billed as if the service were not medically directed.

Medical Direction - Anesthesiologists

Medically directed services are defined as anesthesia services that are medically directed by an anesthesiologist for 1, 2, 3, or 4 qualified individuals, i.e., CRNAs, AAs, interns, residents or combinations of these individuals.

When billing for medically directed services, anesthesiologists should utilize the modifiers listed below:

- QY for medically directed services of 1 qualified individual, i.e., CRNA, AA, intern, resident or combinations of these individuals (effective for 01/01/99)
- QK for medically directed services of 2, 3, or 4 qualified individuals, i.e., CRNAs, AAs, interns, residents or combinations of these individuals.

The payment amount for the physician's service and the qualified individual, i.e., CRNA, AA, intern, resident or combinations of these individuals is 50% of the allowance otherwise recognized had the service been furnished by the anesthesiologist alone.

Medical Direction – Resident

Residents may bill anesthesia services under the supervision of the teaching physician. They are allowed to bill anesthesia procedure codes using the teaching physician's provider number along with an AA and GC modifier.

The term resident includes interns and fellows.

Please refer to the medical supervision requirements indicated in the previous section for billing requirements when concurrent cases (limited to 4) are being supervised by the same physician.

Other Anesthesia Modifiers

Other appropriate anesthesia modifiers for anesthesiologists include the following:

Modifier	***Description***
AA	Anesthesia services performed personally by an Anesthesiologist

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NOTE:

All procedures for anesthesiology services must include appropriate modifiers. CRNAs and AAs are limited to QX and QZ. Anesthesiologists are limited to QY, QK, and AA. Medical directing five or more concurrent cases is not allowed.

38.5.4 Referring Provider Information

Effective February 23, 2008, anesthesia providers must submit the NPI number of the referring surgeon/physician on the claim. If you file hard copy, the NPI number should be populated in block 17a of the CMS 1500 claim form. For those who file electronically, you should submit the referring surgeon/physician's NPI number in REF02 of the 837P. This is necessary for proper claims processing.

Anesthesiologists should use "OTH000" as the referring or attending NPI number for providers who are not assigned a NPI number by Medicare. For example, when providing anesthesia services for recipients who are being treated by dental providers, please use "OTH000" as the NPI number in block 17a of the CMS 1500 form. Use "OTH000" in REF02 and the ID qualifier 1G in REF 01 when filing claims electronically on the 837P. If you use PES software or a vendor, please make sure your software has been updated to accommodate this change. As a reminder, claims for anesthesia providers not containing this information will deny.

38.5.5 Place of Service Codes

Please refer to Chapter 21 for applicable place of service codes for CRNA providers.

38.5.6 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims With Third Party Denials

NOTE:

When an attachment is required, a hard copy CMS-1500 claim form must be submitted.

Refer to Section 5.8, Required Attachments, for more information on attachments.

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38.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find it
CMS-1500 Claim Filing Instructions	Chapter 5
Medical Medicaid/Medicare-related Claim Filing Instructions	Chapter 5
Medical Necessity/Medically Necessary Care	Chapter 7
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N

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