PROVIDER REIMBURSEMENT GUIDANCE			
Anesthesia Services			
Original Date Approved	**Effective Date SCO/ICO**	**Effective Date MAPD***	**Revision Date**
02/10/2022	04/01/2022	04/01/2022	02/01/2022

Scope: Commonwealth Care Alliance (CCA) Product Lines

☒ Senior Care Options (MA)
☒ One Care (MA)
☒ CCA Medicare Preferred – (PPO) MA*
☒ CCA Medicare Value - (PPO) MA*
☒ CCA Medicare Preferred – (PPO) RI*
☒ CCA Medicare Value - (PPO) RI*
☒ Medicare Maximum – (HMO DNSP) RI*

PAYMENT POLICY SUMMARY:

Commonwealth Care Alliance's (CCA) reimbursement policy for anesthesia services is developed in part using the American Society of Anesthesiologists (ASA) Relative Value Guide (RVG®), the ASA CROSSWALK®, and Centers for Medicare and Medicaid Services (CMS) methodology. Current Procedural Terminology (CPT®) codes and modifiers and Health Care Common Procedure Coding System (HCPCS) modifiers identify services rendered. These services may include, but are not limited to, general or regional anesthesia, Monitored Anesthesia Care, or other services to provide the patient the medical care deemed optimal.

The Anesthesia Policy addresses reimbursement of procedural or pain management services that are an integral part of anesthesia services as well as anesthesia services that are an integral part of procedural or pain management services.

REIMBURSEMENT REQUIREMENTS:

Anesthesia Services

Anesthesia services must be submitted with a CPT anesthesia code in the range 00100-01999, excluding 01953 and 01996, and are reimbursed as time-based using the Standard Anesthesia Formula.

For this Anesthesia policy the code range 00100-01999 specifically excludes 01953 and 01996 when referring to anesthesia services. CPT codes 01953 and 01996 are not considered anesthesia services according to the ASA RVG® since they should not be reported as time-based services.

Required Anesthesia Modifiers

All anesthesia services including Monitored Anesthesia Care must be submitted with a required anesthesia modifier in the first modifier position. These modifiers identify whether a procedure was personally performed, medically directed, or medically supervised. CCA will adjust the Allowed Amount by the Modifier Percentage indicated in the table below, consistent with CMS guidelines.

Required Anesthesia Modifiers	Reimbursement Percentage	Provider Type
AA	100%	Anesthesiologist MD Personally Performed
AD	100%	Anesthesiologist MD Supervising over 4
QK	50%	Anesthesiologist MD Supervising 2-4
QX	50%	CRNA or AA Directed by Anesthesiologist MD
QY	50%	Anesthesiologist MD Supervising 1
QZ	100%	CRNA Personally Performed

These CPT and HCPCS modifiers may be reported to identify an altered circumstance for anesthesia and pain management. If reporting CPT modifier 23 and 47 or HCPCS modifiers GC, G8, G9 or QS, no additional reimbursement is allowed above the usual fee for that service.

CPT Modifiers	HCPCS Modifiers
22	GC
23	G8
47	G9
59	QS
76	XE
77	XP
78	XS
79	XU

NOTE: Medicare does not recognize Physical status modifiers.

Reimbursement Formula

Base Values:

The ASA assigns a Base Value to each CPT anesthesia code. CCA Medicare Advantage uses these values for determining reimbursement. The Base Value of each code is comprised of units referred to as the Base Unit Value.

Time Reporting:

CCA Medicare Advantage requires time-based anesthesia services be reported with actual Anesthesia Time in one-minute increments, as directed by CMS guidelines. For instance, if the Anesthesia Time is one hour, then 60 minutes should be submitted.

The ASA indicates that post- surgical pain blocks are frequently placed before anesthesia induction or after anesthesia emergence. If the block is placed before induction or after emergence, the time spent placing the block should not be added to the reported Anesthesia Time; this is true even if sedation and monitoring is provided to the patient during block placement.

Reimbursement Formulas:

Time-based anesthesia services are reimbursed according to the following formulas:

- Standard Anesthesia Formula without Modifier AD* = ([Base Unit Value + Time Units + Modifying Units] x Conversion Factor) x Modifier Percentage.
- Standard Anesthesia Formula with Modifier AD* = ([Base Unit Value of 3 + 1 Additional Unit if anesthesia notes indicate the physician was present during induction] x Conversion Factor) x Modifier Percentage

Qualifying Circumstances

Qualifying circumstances codes identify conditions that significantly affect the nature of the anesthetic service provided. CCA Medicare Advantage does not allow additional base units for qualifying circumstance codes. The qualifying circumstances codes are 99100, 99116, 99135 and 99140.

Multiple or Duplicate Anesthesia Services

Multiple Anesthesia Services:

As outlined by the ASA, when multiple surgical procedures are performed during a single anesthesia administration, only the single anesthesia code with the highest Base Unit Value should be reported. The time reported is the combined total for all procedures performed on the same patient on the same date of service by the same or different physician or other qualified health care professional.

Code 01953 is an add-on-code and is used in conjunction with code 01952. Codes 01968 and 01969 are add-on-codes and are used in conjunction with code 01967. Anesthesia add-on codes are priced differently. Only the base unit of the add-on code should be allowed. The Anesthesia Time should be reported with the primary anesthesia code.

Duplicate Anesthesia Services:

When duplicate anesthesia codes are reported by the same or different physician or other qualified health care professional for the same patient on the same date of service, CCA Medicare Advantage will only reimburse the first submission of that code. However, anesthesia administration services can be rendered simultaneously by an MD and a CRNA during the same operative session, each receiving 50% of the Allowed Amount (as indicated in the Modifier Table above) by reporting modifiers QK or QY and QX.

If an anesthesia administration service is provided during a different operative session on the same day as a previous operative session, CCA will reimburse one additional anesthesia administration appended with modifier 59, 76, 77, 78, 79, XE, XP or XU. As with the initial anesthesia administration, only the single anesthesia code with the highest Base Unit Value should be reported.

Preoperative/Postoperative Visits

CCA Medicare Advantage will not separately reimburse an E/M service (excluding critical care CPT codes 99291-99292) when reported by the Same Specialty Physician or Other Qualified Health Care Professional on the same date of service as an anesthesia service.

Critical care CPT codes 99291-99292 are not considered included in an anesthesia service and will be separately reimbursed.

The Same Specialty Physician or Other Qualified Health Care Professional is defined as physicians and/or other qualified health care professionals of the same group and same specialty reporting the same Federal Tax Identification number.

Daily Hospital Management

Daily hospital management of epidural or subarachnoid drug administration (CPT code 01996) in a CMS place of service 21 (inpatient hospital), 22 (outpatient hospital) or 25 (birthing center) is a separately reimbursable service once per date of service excluding the day of insertion. CPT code 01996 is considered included in the pain management procedure if submitted on the same date of service by the Same Individual Physician or Other Qualified Health Care Professional.

If the anesthesiologist continues with the patient's care after discharge, the proper Evaluation and Management code should be used.

For purposes of this policy, Same Physician or Other Qualified Health Care Professional is defined as the same individual rendering health care services reporting the same Federal Tax Identification number.

REFERRAL/NOTIFICATION/PRIOR AUTHORIZATION REQUIREMENTS:

For more information on prior authorizations, please refer to the Prior Authorization Requirements in the plan specific Provider Manual.

BILLING AND CODING GUIDELINES:

Anesthesia and Procedural Bundled Service

CCA Medicare Advantage uses the CMS National Correct Coding Initiative (NCCI) Policy Manual, CMS NCCI edits and the CMS National Physician Fee Schedule when considering procedural or pain management services that are an integral part of anesthesia services, and anesthesia services that are an integral part of procedural or pain management services, which are not independently reimbursable when performed by the Same Individual Physician or Other Qualified Health Care Professional on the same date of service. The CMS NCCI Policy manual states that "many standard preparation, monitoring, and procedural services are considered integral to the anesthesia service. Although some of the services would never be appropriately reported on the same date of service as anesthesia management, many of these services could be provided at a separate patient encounter unrelated to the anesthesia management on the same date of service." According to the NCCI Policy Manual, Chapter 1, CMS does not allow separate payment for anesthesia services performed by the physician who also furnishes the medical or surgical procedure, excluding Moderate Sedation. In these situations, the allowance for the anesthesia service is included in the payment for the medical or surgical procedure. In addition, AMA states “if a physician personally performs the regional or general anesthesia for a surgical procedure that he or she also performs, modifier 47 would be appended to the surgical code, and no codes from the anesthesia section would be used.” CCA will not separately reimburse an anesthesia service when reported with a medical or surgical procedure (where the anesthesia service is the direct or alternate crosswalk code for the medical or surgical procedure) submitted by the Same Individual Physician or Other Qualified Health Care Professional for the same patient on the same date of service.

DISCLAIMER:

As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to patient eligibility and benefits on the date of service, coordination of benefits, referral/authorization, and utilization management guidelines when applicable and adherence to CCA policies and procedures and claims editing logic. CCA has the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that your office/facility did not comply with this payment policy, CCA has the right to expect your office/facility to refund all payments related to non-compliance.

REFERENCES:

CMS Website

CCA Website

American Medical Association (AMA) Current Procedural Terminology (CPT®)

American Society of Anesthesiologists (ASA): Relative Value Guide®

Centers for Medicare and Medicaid Services: Anesthesiologists Center

Medicare Claims Processing Manual - Chapter 12 - Physicians/Nonphysician Practitioners: Section 50, 100, 140

National Correct Coding Initiative Edits: NCCI Policy Manual for Medicare - Chapters I and II

Payment Policies:
Massachusetts / Rhode Island

Provider Manuals:
Massachusetts / Rhode Island

Prior Authorization Forms:
Massachusetts / Rhode Island

POLICY TIMELINE DETAILS

1. July 2020 drafted
2. Effective 12/01/2020
3. Updated 07/02/2021: Added two new biosimilars: Nyvepria (pegfilgrastim-apgf), Q5122 and Riabni (rituximab-arrx), Q5123; Added Epoetin Alfa, J0885 and Q5106
4. Revised October 2021; added MAPD