PROVIDER REIMBURSEMENT GUIDANCE			
Obstetric Anesthesia Services			
Original Date Approved	Effective Date Senior Care Options/One Care	Effective Date Medicare Advantage*	Revision Date
05/10/2022	08/01/2022	08/01/2022	

Scope: Commonwealth Care Alliance (CCA) Product Lines

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

PAYMENT POLICY SUMMARY:

Commonwealth Care Alliance® (CCA) reimburses for covered services including, but not limited to, general or regional anesthesia, supplementation of local anesthesia, or other supportive services. These services include the usual pre-operative and post-operative visits, the anesthesia care during the procedure, the administration of fluids and/or blood, and the usual monitoring services (e.g., ECG, blood pressure, oximetry, temperature, capnography, and mass spectrometry).

Definitions:

Obstetric anesthesia services include procedures for providing anesthesia during childbirth, including:

- **Cesarean-section** – epidural/spinal block or general anesthesia
- **Episiotomy** – local anesthesia for performance or repair
- **Labor and delivery** – paracervical or pudendal block
- **Labor and delivery, wider block** – epidural, spinal, caudal, or saddle block

Anesthesia Time: Anesthesia Time begins when the Anesthesia Professional prepares the patient for the induction of anesthesia in the operating room or in an equivalent area (i.e., a place adjacent to the operating room) and ends when the Anesthesia Professional is no longer in personal attendance and when the patient may be safely placed under postoperative supervision. Anesthesia Time involves the continuous actual presence of the Anesthesia Professional.

Base Unit Value: The number of units which represent the Base Value (per code) of all usual anesthesia services, except the time actually spent in anesthesia care and any Modifying Units.

Time Units: the derivation of units based on time reported which is divided by a time increment for example, one- or 15-minute increments.

AUTHORIZATION REQUIREMENTS:

Applicable CCA referral, notification and authorization policies and procedures apply. For more information on prior authorizations, please refer to the Prior Authorization Requirements in the plan specific Provider Manual.

REIMBURSEMENT GUIDELINES:

CCA uses the “Base Values” plus anesthesia time units multiplied by a conversion factor for determining reimbursement and Time Reporting consistent with CMS must be reported with actual anesthesia time.

BILLING and CODING GUIDELINES:

CCA limits reimbursement for the following obstetric anesthesia services to the maximum allowable times listed in the table below:

CPT Codes – Obstetric Anesthesia Services:

Code	Description
01960	Anesthesia for vaginal delivery only
01961	Anesthesia for Cesarean-section only
01962	Anesthesia for urgent hysterectomy following delivery
01963	Anesthesia for Cesarean-section hysterectomy, without labor analgesia/anesthesia care
01967	Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)
01968	Anesthesia for Cesarean-section delivery, following neuraxial labor analgesia/anesthesia care, (List separately in addition to code for primary procedure performed)
01969	Anesthesia for Cesarean-section hysterectomy, following neuraxial labor analgesia/anesthesia care, (List separately in addition to code for primary procedure performed)

When reporting services, providers/facilities should code to the highest level of specificity using the code that was in effect on the date the service was rendered.

All anesthesia services must be reported with an appropriate anesthesia modifier in the primary position. The following modifiers indicate whether the service was provided by an anesthesiologist, medically supervised, or medically directed.

Modifiers Used by Anesthesiologists:

- Modifier AA Anesthesia services performed personally by an anesthesiologist
- Modifier AD Medical supervision by a physician more than four concurrent anesthesia procedures
- Modifier QK Medical direction of two, three or four concurrent anesthesia procedures
- Modifier QY Anesthesiologist medically directs one CRNA

BILLING and CODING GUIDELINES (cont.):

Modifiers Used by CRNAs

- Modifier QX CRNA service with medical direction by a physician
- Modifier QZ CRNA service without medical direction by a physician

RELATED SERVICE POLICIES:

Maximum Units

AUDIT and 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 member eligibility and benefits on the date of service, coordination of benefits, referral/authorization, and utilization management guidelines when applicable and adherence to plan policies, 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:

- American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services
- American Society of Anesthesiologists, Relative Value Guide®
- Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
- Centers for Medicare and Medicaid Services, National Correct Coding Initiative (NCCI) publications
- Centers for Medicare and Medicaid Services, Physician Fee Schedule (PFS) Relative Value Files
- National Uniform Claim Committee (NUCC)
- Publications and services of the American Society of Anesthesiologists (ASA)

POLICY TIMELINE DETAILS:

1. Effective 08/01/2022