Payment Policy: Anesthesia

Reference Number: CC.PP.02
Product Types: Medicaid
Effective Date: 08/01/2018
Last Review Date: 09/01/2021

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Anesthesia Billing Guidelines
The anesthesia procedure codes (00100 – 01999) listed in the current year's CPT manual, are the only anesthesia codes eligible for reimbursement. Use of a surgical code with an anesthesia modifier is not an acceptable billing method. Failure to use appropriate anesthesia coding may result in denial of the procedure or service.

Anesthesia Reimbursement
Anesthesia time starts when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the patient, that is, when the patient may be placed safely under postoperative care. Actual anesthesia time is reported in minutes. Anesthesia reimbursement is calculated as follows:

ASA Base Code Units + Anesthesia Units x Anesthesia Fee Schedule Rate

Unit Conversion
15 Minutes of Anesthesia = 1 Unit

Total units will be rounded up to the nearest whole unit for any partial anesthesia time after the last full 15 minute increment.

Modifiers
The Plan accepts anesthesia modifiers when billed with appropriate CPT codes that identify an anesthesia service.

Personally Performed
Personally performed anesthesia services are paid using the standard rate calculation for anesthesia services, as outlined in the provider contract

Medically Directed Anesthesia Services
Where a single anesthesia procedure involves both a physician medical direction service and the service of the medically directed certified registered nurse anesthetist (CRNA), the payment amount for each separate service may be no greater than 50 percent of the allowance had the service been furnished by the anesthesiologist alone.

- Modifier QK must be used to indicate the physician medically directed service of two, three, or four concurrent anesthesia procedures.
- Modifier QY must be used to indicate medical direction of one CRNA by an anesthesiologist.

Reimbursement for CRNA Services
The Plan will utilize the anesthesiology base unit(s) and conversion factor values when calculating CRNA payment rates.

- Modifier QX must be used by the CRNA to indicate services that were medically directed by a physician – reimbursement will be 50% of the base procedure code reimbursement rate
- Modifier QZ must be used by the CRNA to indicate services that were without medical direction of a physician – reimbursement will be 100% of the base procedure code reimbursement rate

Documentation Requirements
Not Applicable.

Coding and Modifier Information
This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2021, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current 2021 manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT Code	Descriptor	Maximum Time Allowed
01960	Anesthesia for vaginal delivery only	60 minutes
01961	Anesthesia for cesarean delivery only	120 minutes
01962	Anesthesia for urgent hysterectomy following delivery	120 minutes
01963	Anesthesia for cesarean hysterectomy, without any labor analgesia/anesthesia care	240 minutes
01967	Analgesia/anesthesia for planned vaginal delivery	300 minutes
01968	Anesthesia for cesarean delivery, following neuraxial labor analgesia/anesthesia	360 minutes
01969	Anesthesia for cesarean hysterectomy, following neuraxial labor analgesia/anesthesia	480 minutes

Modifier	Descriptor	Comments
AA	Anesthesia services performed personally by anesthesiologist	Allows 100% of the fee schedule payment based on the unit rate
AD	Medical supervision for more than four concurrent anesthesia procedures is provided (documentation required)	

QZ	CRNA performed services without medical direction	Allows 100% of the fee schedule based on the unit rate
QY	Medical direction of one CRNA by an anesthesiologist	Allows for 50% of the allowable reimbursed to an anesthesiologist performing the service
QK	Medical direction of two, three, or four concurrent anesthetic procedures involving qualified individuals (e.g. CRNAs or residents)	
QX	CRNA performed services under the medical direction of an anesthesiologist	

ICD 10 Codes	Descriptor
NA	Not Applicable

Additional Information
Not Applicable

Related Documents or Resources
Not Applicable

References
1. *Current Procedural Terminology (CPT)*®, 2021
2. *HCPCS Level II*, 2021

Revision History	
4/1/2018	Initial Policy Draft
8/31/2021	New format; Add-on code language removed

Important Reminder
For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable

legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

This payment policy is the property of Centene Corporation. Unauthorized copying, use, and distribution of this payment policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.