PAYMENT POLICY

Anesthesia

POLICY NUMBER:	**NH.PP.02**	**ORIGINAL EFFECTIVE DATE:**	**08/01/2017**
PRODUCT TYPE(S):	**Medicaid**	**REVISION EFFECTIVE DATE:**	

IMPORTANT REMINDER

This policy is current at the time of publication. Centene Corporation retains the right to change or amend this policy at any time.

While this policy provides guidance regarding reimbursement, it is not intended to address every reimbursement situation. In instances that are not specifically addressed by this policy, or addressed by another policy or contract, Centene Corporation retains the right to use reasonable discretion in interpreting this policy and applying it (or not applying it) to the reimbursement of services provided to all or certain members. The provider is responsible for the accuracy of all claims.

Providers and members are bound by the foregoing terms and conditions, in addition to the Site Use Agreement for Health Plans associated with Centene Corporation.

Note: For Medicaid members, when state Medicaid coverage provisions are controlling and conflict with the coverage provisions in this policy, state Medicaid coverage provisions take precedence. In such instance, please refer to the state Medicaid manual for any coverage provisions pertaining to this policy.

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Policy Reimbursement

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.

Add-On Codes

When an add-on code is used with an anesthesia code, reimbursement will be calculated for both the primary and add-on procedure codes, in addition to the total time for the complete procedure.

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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

Specific Terms of Reimbursement for Anesthesia Care

The following specific terms of payment apply to anesthesia services rendered to a Plan member.

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Coding and Modifier Information

Applicable coding is listed below, subject to codes being active on the date of service. Because the American Medical Association (AMA), Centers for Medicare & Medicaid

Services (CMS), and the U.S. Department of Health and Human Services may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes may not be all inclusive. These codes are not intended to be used for coverage determinations.

Modifier	Description	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 payment 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	

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Obstetrical Procedure Code	Description	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

Additional Information

References

REVISION HISTORY	