519.2 ANESTHESIA SERVICES

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519.2 ANESTHESIA SERVICES

BACKGROUND

Anesthesia services covered by West Virginia Bureau for Medical Services (BMS) include regional anesthesia (e.g. caudal, epidural, axillary block, etc.), deep sedation, general anesthesia, and monitored anesthesia care (MAC). Moderate/conscious sedation is bundled into the procedure being provided and must not be billed as a separate service.

POLICY

519.2.1 Covered Services

The BMS applies the following policies for coverage and reimbursement of anesthesia services:

- Payment for multiple anesthesia procedures is based on the procedure with the highest base unit value and the actual anesthesia time of the multiple procedures. Only one zero code may be billed (the highest value):
    - Exception: Procedures performed at the same time as a delivery are included in the maternity service and must be billed with the maternity anesthesia current procedural terminology (CPT) codes.
- Anesthesia time begins when the certified registered nurse anesthetist (CRNA) or anesthesiologist begins to prepare the member for anesthesia care in the operating room or an equivalent area, and ends when the CRNA or the anesthesiologist is no longer in personal attendance.
- Preoperative evaluations for anesthesia are included in the fee for the administration of anesthesia and may not be billed as an evaluation and management service.
- Regional IV anesthesia is not based on time units; the base unit is covered. Therefore, only one unit of service may be billed.
- The CPT surgical procedure codes are used for regional anesthesia. No base units or time units of anesthesia may be billed. Instead, one unit of service (an injection) is billed.
- Daily management of epidural or subarachnoid drug administration is not payable on the same day as the insertion of an epidural catheter or a general anesthesia service. The service unit for this procedure is one base unit.
- Epidural anesthesia for surgical procedures must be billed with the appropriate anesthesia code with time units.
- Medications for pain relief given during the time of the epidural anesthesia are included and must not be billed as a separate procedure.
- Local anesthesia and intravenous (IV) (conscious) sedation are bundled into the procedure being provided and must not be billed as separate services.
- Anesthesia services rendered during a hysterectomy or sterilization require completion, submission, and acceptance of the appropriate acknowledge/consent forms.
- Because of unusual circumstances, a procedure which usually requires no anesthesia or local anesthesia may require general anesthesia. A written description of the reason for using the modifier is required, and the claim will be sent for review.
- Modifiers defining the CRNA or anesthesiologist participation are used in processing to allocate payments. The supervising/medical directing anesthesiologist/CRNA must bill the same procedure code.

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- Physical status modifiers are not used for processing by the BMS. The billing of additional base units for physical status is prohibited.

519.2.1.1 Anesthesiologist Directed Services

Anesthesiologist direction may apply to anesthesia service(s) provided by a single or multiple CRNAs. An anesthesiologist directing the administration of anesthesia is not expected to be involved routinely in providing any additional services to other members. The anesthesiologist must document in the member's medical record that all medical direction requirements have been met, including:

- Performs the pre-anesthetic examination and evaluation;
- Prescribes the anesthesia plan;
- Participates personally in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence;
- Ensures a qualified individual performs any procedure in the anesthesia plan he/she does not perform personally;
- Monitors the course of anesthesia administration at frequent intervals;
- Remains physically present and available for immediate diagnosis and treatment of emergent situations that may develop; and
- Provides indicated post-anesthesia care.

An anesthesiologist may appropriately receive members entering the operating suite for the next surgery while directing concurrent anesthesia procedures. However, checking or discharging members in the recovery room and handling scheduling matters are not compatible with reimbursement to the anesthesiologist for directing concurrent anesthesia procedures.

An anesthesia team is defined as one directing anesthesiologist and one CRNA providing services to a member. The payment divided between the anesthesiologist and medically-directed CRNA equals 100% of the payment level for an individually performing anesthesiologist. An anesthesiologist directing the administration of anesthesia for more than four concurrent procedures will be reimbursed at a reduced rate. Only one provider or anesthesia team will be paid for epidural anesthesia.

Certified Registered Nurse Anesthetist (CRNA): The CRNA must have a diploma or certificate evidencing his/her successful completion of an educational program from a school of anesthesia accredited by the American Association of Nurse Anesthetists (AANA).

The CRNA must submit a copy of the hospital's approval through the credentialing and delineation of privileges process to BMS' fiscal agent for inclusion in the CRNA's enrollment record.

When general, regional, and monitored anesthesia is administered, the CRNA may be supervised by the operating practitioner performing the procedure but an anesthesiologist must be immediately available, as required by licensure. The CRNA may bill directly to the appropriate fiscal agent with their assigned National Provider Identifier (NPI) and must include the appropriate modifier on the claim form. The claim will be denied if the appropriate modifier is not included on the claim form.

Anesthesiologist Assistant (AA): The AA is a highly skilled, non-physician anesthetist who works under the direction of licensed anesthesiologists to implement anesthesia care plans and may also be a part of the anesthesia team. The AA is not licensed to administer general, regional, or monitored anesthesia. The AA works exclusively within the anesthesia care team environment as described by the American

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Society of Anesthesiologists (ASA). Upon completion of an accredited AA program, a student must fulfill certification and re-certification processes as set forth by the National Commission for Certification of Anesthesiologist Assistants (NCCAA).

519.2.1.2 Emergency Anesthesia

An emergency exists when delay in treatment would lead to a significant increase in threat to life or body part. In these cases, the ASA recommended payment policy is followed.

If the member undergoes a documented emergent cesarean section, the anesthesia provider may receive reimbursement for up to two additional units of anesthesia.

519.2.1.3 Monitored Anesthesia Care (MAC)

MAC involves the intraoperative monitoring of the member's physiological signs in anticipation of the development of adverse reactions to the procedure or the need for administration of general anesthesia. When general, regional, or monitored anesthesia is administered, the CRNA must be supervised by the operating practitioner performing the procedure, or by an anesthesiologist who is immediately available if needed. MAC must be performed at the request of the attending physician, made known to the member, and performed according to the facility's policies and procedures. If medically necessary, MAC is reimbursed on the same basis as other anesthesia services.

The BMS reimburses for MAC only if all of the following requirements are met by the anesthesiologist or CRNA:

- Performs a pre-anesthetic examination and evaluation of the member;
- Prescribes the required anesthesia;
- Participates personally in the entire plan of care;
- Is continuously physically present when participating in the case;
- Observes all facility regulations pertaining to anesthesia services; and
- Provides all the usual services an anesthetist usually performs.

Monitored anesthesia must be documented on claims using the appropriate modifier(s).

519.2.1.4 Maternity-Related Anesthesia

The BMS limits payment for maternity anesthesia to eight-time units (a maximum of two hours). Base units may not be billed separately.

The BMS payment policy for labor epidural is as follows:

- Medications for pain relief given during the time of the epidural anesthesia are not covered as a separate procedure.
- Only one provider or team will be paid for epidural services.
- Emergency anesthesia is not allowed with the provision of epidural anesthesia or vaginal deliveries.
- The labor epidural procedures covered by the BMS are inclusive of labor, delivery, and postpartum care. Additional procedure codes used for pain management are not covered.

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519.2.1.5 Other Anesthesia Services

Anesthesiologists and CRNAs within the scope of their license may bill for the following additional services:

- Swan-Ganz placement or any other central venous pressure line;
- Critical care visits;
- Emergency intubations;
- Spinal puncture; and
- Blood patch.

Payment for these specific services is based on the resource-based relative value scale (RBRVS) payment system. Time units are not billable for these services.

Providers may also bill for cardiopulmonary resuscitation (CPR) performed in conjunction with the anesthesia procedure or outside the operating suite.

519.2.1.6 Dental Anesthesia Services

For information on dental anesthesia, please refer to *Chapter 505, Oral Health Services*.

519.2.2 Billing for Anesthesiology Services

The BMS follows the American Society of Anesthesiologists (ASA) current definitions of sedation as detailed in its "Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia." Anesthesia time begins when the practitioner, having completed the preoperative evaluation, starts an intravenous line, places monitors, administers pre-anesthesia sedation, or otherwise physically begins to prepare the member for anesthesia. Time continues throughout the case and while the practitioner accompanies the member to the post-anesthesia care area. Time stops when the practitioner releases the member to the care of the post-anesthesia care area personnel. Anesthesia must be billed in minutes.

The BMS requires that all anesthesia services be billed with a modifier indicating the professional level of the provider, with the exception of Regional IV administration of local anesthetic agent upper or lower extremity and daily management of epidural. For example, the anesthesiologist must bill using the following anesthesia payment modifiers: AA, AD, QK, QS, or QY to designate that the service was provided by an anesthesiologist, and the CRNA must bill either QS, QX, or QZ to designate that a CRNA provided the service.

Maternity anesthesia is limited to a maximum of 120 minutes regardless of the different types of anesthesia services provided during labor and delivery. All other anesthesia services provided over the maximum time of 600 minutes must be submitted on a paper claim to the fiscal agent accompanied with anesthesia progress notes. Physicians who administer anesthesia as part of an office procedure must have a certificate/permit as defined in WV State Code Chapter 30-4A-1.

Generally, two distinct unit values, base and time, apply to anesthesia services. The base units for a given anesthesia service are the same every time the service is provided and have been established by the ASA in their relative value guide. Base units are hard coded in the BMS fiscal agent's claim

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processing system and **are not** to be billed by the practitioner.

Time units depend on the length of time needed to provide the anesthesia service. The BMS defines a time unit as 15 minutes which must be rounded to the nearest whole unit (seven minutes or less = round down; eight minutes or more = round up). For example, a service that takes 70 minutes would be assigned five time units. Provider will report the total anesthesia time in minutes in the unit field.

For most anesthesia services, the BMS reimbursement allowance is determined by the sum of the ASA base units plus time units multiplied by the anesthesia conversion factor. There is a limit of 600 minutes for each anesthesia episode, with the exception of maternity anesthesia. However, the BMS may consider reimbursement of non-maternity anesthesia over 600 minutes when surgery time is extended based on the complexity of the procedure and life-saving procedures. Anesthesia services over 600 minutes are subject to medical necessity review.

Specific anesthesia services are reimbursed using ASA base units only; time units do not apply. The BMS establishes the relative value for these services so the fee on the RBRVS fee schedule equals the number of base units multiplied by the anesthesia conversion factor. In addition, other anesthesia services, such as insertion of an arterial line, are reimbursed using the RBRVS; base units and time units do not apply.

Non-Covered services are not eligible for the West Virginia Department of Health and Human Resources (DHHR) Fair Hearings or Desk/Document Reviews. See 42 § 431.220 When a hearing is required for more information.

GLOSSARY

Definitions in *Chapter 200, Definitions and Acronyms* apply to all West Virginia Medicaid services, including those covered by this chapter. Definitions in this glossary are specific to this chapter.

Certified Registered Nurse Anesthetist (CRNA): An individual licensed by the West Virginia Board of Examiners for Registered Professional Nurses as a registered professional nurse who holds advanced certification to administer anesthesia in the presence of and under the supervision of a physician or dentist.

CHANGE LOG

REPLACE	TITLE	EFFECTIVE DATE
Entire Chapter	Anesthesia Services	January 15, 2016
Entire Chapter	Changed units to minutes when describing billing. Clarified Anesthesiologist Directed Services including the removal of four concurrent surgery limit.	April 1, 2020

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