Title: Anesthesia Payment Policies

Origination:	9/15/2014	Revision:	4/5/2020

Scope

This policy applies to all products, all network and non-network physicians, and other qualified health care professionals.

Overview

AvMed's reimbursement policy for anesthesia services is developed in part using the Centers for Medicare and Medicaid (CMS) National Correct Coding Initiative (NCCI) Policy Manual, CMS NCCI edits, the CMS National Physician Fee Schedule, and other proprietary methodologies.

Reimbursement Guidelines

Anesthesia services must be submitted with a CPT anesthesia code in the range 00100-01999 and are reimbursed utilizing a time-based methodology according to the standard anesthesia formula.

Reimbursement Methodology

Base Value:
Each CPT anesthesia code (00100-01999) is assigned a Base Value by CMS and subject to updates by CMS. The Base Value includes usual pre-operative and post-operative visits, the administration of fluids and/or blood products incident to the anesthesia care and interpretation of non-invasive monitoring. When multiple surgical procedures are performed during a single anesthesia administration, only the single anesthesia code with the highest Base Value is reported.

Time Based Units:
AvMed requires time-based anesthesia services be reported with actual Anesthesia Time in one-minute increments. The Anesthesia Time begins when anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the patient. If there is a conflict between Anesthesia Time reported by anesthesia practitioner on the professional claim and the Anesthesia Time reported in the medical record produced by the facility where the services were rendered, the Anesthesia Time listed in the medical record produced by the facility will be the basis for reimbursement.

Placement of post-surgical pain blocks placed before anesthesia induction or after anesthesia emergence are not to be added to the reported anesthesia time.

Depending on the provider contract, AvMed will convert the Anesthesia Time into either 10 minute or 15 minute Time Based Units. The Time Based Units will be rounded to the first decimal.

Modifiers:
All anesthesia services must be submitted with a required concurrency modifier in the first modifier position that identifies whether a procedure was personally performed, medically directed, or medically supervised. Consistent with CMS, AvMed will adjust the allowed amount by the modifier percentage listed in the table below.

Concurrency Modifier	Description	Allowed Percentage
AA	Anesthesia services performed personally by an anesthesiologist	100%
AD	Medical supervision by a physician with more than four concurrent anesthesia procedures	100%
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals	50%
QX	Qualified non-physician anesthetist with medical direction by a physician	50%
QY	Medical direction of one qualified non-physician anesthetist by an anesthesiologist	50%
QZ	CRNA service without medical direction by a physician	100%

Consistent with CMS and industry standards, AvMed does not separately reimburse for Physical Status Modifiers (P1 – P5).

Reimbursement Formula:
(Base Unit Value + Time Units) **X** Conversion Factor **X** Concurrency Modifier Percentage= Allowed Amount

Qualifying Circumstances:
Qualifying circumstances codes identify conditions that significantly affect the nature of the anesthesia services provided and should only be billed in addition to the anesthesia service with the highest Base Value. If the member meets the clinical criteria for the qualifying circumstances codes and are billed with the appropriate anesthesia code, the Modifying Units (see table below) will be added to the Base Value.

Procedure Code	Description	Modifying Units
99100	Anesthesia for patient of extreme age; younger than 1 year and older than 70 **(code is not allowed with anesthesia codes 00326, 00561, 00834, and 00836)**	1
99116	Anesthesia complicated by utilization of total body hypothermia **(code is not allowed with anesthesia codes 00561, 00562, 00563, and 00567)**	5
99135	Anesthesia complicated by utilization of controlled hypotension **(code is not allowed with anesthesia codes 00561, 00562, 00563, and 00567)**	5
99140	Anesthesia complicated by emergency conditions	2

Obstetric Anesthesia Services:
Effective 7/15/20, AvMed will reimburse neuraxial labor analgesia (CPT code 01967) based on the Reimbursement Formula subject to a cap of 435 minutes. Add-on CPT Codes 01968 and 01969 (C-Section Anesthesia) will be eligible for reimbursement when billed with the primary CPT code 01967 (Vaginal Delivery Anesthesia).