	Reimbursement Policy

Subject: Professional Anesthesia Services

Effective Date:	Committee Approval Obtained:	Section:
10/01/17	**10/03/18**	**Anesthesia**

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed version of this policy, please verify the information by going to https://providers.amerigroup.com/DC. *****

These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member's Amerigroup District of Columbia, Inc. benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's District of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with CPT codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Amerigroup may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

Amerigroup reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider, District, federal or CMS contracts and/or requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, Amerigroup strives to minimize these variations.

Amerigroup reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to this site.

Policy	Amerigroup allows reimbursement of anesthesia services rendered by professional providers for covered members unless provider, District, federal or CMS contracts and/or requirements indicate otherwise. Reimbursement is based upon: • The reimbursement formula for the allowance and time increments in accordance with CMS. • Proper use of applicable modifiers. Providers must report anesthesia services in minutes. Anesthesia claims submitted with an indicator other than minutes may be

	rejected or denied. Start and stop times must be documented in the member's medical record. Anesthesia time **starts** with the preparation of the member for administration of anesthesia and **stops** when the anesthesia provider is no longer in personal and continuous attendance. The reimbursement formula for anesthesia allowance is based on CMS guidelines unless otherwise noted in the exemption section. **Anesthesia Modifiers** Anesthesia modifiers are appended to the applicable procedure code to indicate the specific anesthesia service or who performed the service. Modifiers identifying who performed the anesthesia service must be billed in the primary modifier field to receive appropriate reimbursement. Additional or reduced payment for modifiers is based on District requirements as applicable. If there is no District requirement, Amerigroup will default to the following CMS guidelines. Claims submitted for anesthesiology services without the appropriate modifier will be denied. • **Modifier AA:** anesthesiology service performed personally by an anesthesiologist — reimbursement is based on 100 percent of the applicable fee schedule or contracted/negotiated rate • **Modifier AD:** medical supervision by a physician; more than four concurrent anesthesia procedures — reimbursement is based on 100 percent of the applicable fee schedule or contracted/negotiated rate for up to three base units for anesthesiologists • **Modifier QK:** medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals — reimbursement is based on 50 percent of the applicable fee schedule or contracted/negotiated amount • **Modifier QX:** qualified nonphysician anesthetist with medical direction by a physician — reimbursement is based on 50 percent of the applicable fee schedule or contracted/negotiated amount • **Modifier QY:** anesthesiologist medically directs one certified registered nurse anesthetist (CRNA) — reimbursement is based on 50 percent of the applicable fee schedule or contracted/negotiated amount • **Modifier QZ:** CRNA service without medical direction by a physician — reimbursement is based on 100 percent of the applicable fee schedule or contracted/negotiated amount • **Modifier 23:** denotes a procedure that must be done under general anesthesia due to unusual circumstances although normally done under local or no anesthesia — reimbursement is based on 100 percent of the applicable fee schedule or contracted/negotiated rate of the procedure; Modifier 23 does

	not increase or decrease reimbursement; it substantiates billing anesthesia associated with the procedure in cases where anesthesia is not usually appropriate • **Modifier 47:** denotes regional or general anesthesia services provided by the surgeon performing the medical procedure; Amerigroup does not allow reimbursement of anesthesia services by the provider performing the medical procedure (other than obstetrical, see Obstetrical Anesthesia section of this policy); therefore, it is not appropriate to bill Modifier 47 with anesthesia services **Multiple Anesthesia Procedures** Amerigroup allows reimbursement for professional anesthesia services during multiple procedures. Reimbursement is based on the anesthesia procedure with the highest base unit value and the overall time of all anesthesia procedures. **Obstetrical Anesthesia** Amerigroup allows reimbursement for professional neuraxial epidural anesthesia services provided in conjunction with labor and delivery for up to 300 minutes by either the delivering physician or a qualified provider other than the delivering physician based on the time the provider is physically present with the member. Providers must submit additional documentation upon dispute for consideration of reimbursement of time in excess of 300 minutes. Reimbursement is based on one of the following: • For the delivering physician — based on a flat rate or fee schedule using the surgical CPT pain management codes for epidural analgesia • For a qualified provider other than the delivering physician — based on: o The allowance calculation o The inclusion of catheter insertion and anesthesia administration **Services Provided in Conjunction with Anesthesia** Amerigroup allows separate reimbursement for the following services provided in conjunction with the anesthesia procedure or as a separate service. Reimbursement is based on the applicable fee schedule or contracted/negotiated rate with no reporting of time: • Swan-Ganz catheter insertion • Central venous pressure line insertion • Intra-arterial lines • Emergency intubation (must be provided in conjunction with the anesthesia procedure to be considered for reimbursement)

	• Critical care visits • Transesophageal echocardiography **Nonreimbursable** Amerigroup does not reimburse for: • Use of patient status modifiers or qualifying circumstances codes denoting additional complexity levels. • Anesthesia consultations on the same date as surgery or the day prior to surgery if part of the preoperative assessment. • Anesthesia services performed for noncovered procedures including services considered not medically necessary, experimental and/or investigational. • Anesthesia services by the provider performing the basic procedure except for a delivering physician providing continuous epidural analgesia. • Local anesthesia considered incidental to the surgical procedure. • Standby anesthesia services.
History	• Biennial review approved **10/03/18** • Initial approval **07/19/17** and effective **10/01/17**
References and Research Materials	This policy has been developed through consideration of the following: • CMS • DC Department of Health Care Finance policies • Amerigroup contract with the DC Department of Health Care Finance • American Society of Anesthesiologists • Optum Learning: Understanding Modifiers, 2016 edition
Definitions	• **Anesthesia**: refers to the drugs or substances that cause a loss of consciousness or sensitivity to pain • **Base Unit**: the relative value unit associated with each anesthesia procedure code as assigned by CMS • **Time Unit**: an increment of 15 minutes where each 15-minute increment constitutes one time unit • **Conversion Factor**: a geographic-specific amount that varies by the locality where the anesthesia is administered • **General Reimbursement Policy Definitions**
Related Policies	• Maternity Services • Modifier Usage • Scope of Practice • Reduced and Discontinued Services
Related Materials	• None