WellSense HEALTH PLAN

Payment Policy

Anesthesia

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Impacted Products

- ☐ **All Products**
- ☐ NH Medicaid
- ☒ NH Medicare Advantage
- ☐ MA MassHealth ACO
- ☐ MA MassHealth MCO
- ☐ MA Qualified Health Plans/Employer Choice Direct
- ☐ MA Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan reimburses covered services based on the provider's contractual rates with the Plan and the terms of reimbursement identified within this policy.

Prior-Authorization

Please refer to the Plan's Prior Authorization Requirements Matrix at www.wellsense.org.

Definitions

Anesthesia - the loss of feeling or sensation as a result of medications or gases. General anesthesia causes loss of consciousness. Local or regional anesthesia numbs only a certain area.

Base Unit - the relative value unit associated with each anesthesia procedure code as assigned by The Centers for Medicare and Medicaid Services (CMS).

Conversion Factor: a geographic-specific amount that varies by the locality where the anesthesia is administered

Time Unit - an increment of 15 minutes where each 15-minute increment constitutes one time unit

Provider Reimbursement

The Plan reimburses anesthesia services based on CMS guidelines. The following formula is used to calculate anesthesia payment:

(Base units + Time units) x Conversion Factor

Determining Anesthesia Time and Time Units

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 on the claim in minutes. The Plan then divides anesthesia minutes by 15 (rounded up to one decimal place) to determine the time units.

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.

Medically Directed Anesthesia Services

Payment will be made at the medically directed rate if the physician medically directs qualified individuals (all of whom could be CRNAs, anesthesiologists' assistants, interns, residents, or combinations of these individuals) in two, three, or four concurrent cases and the physician renders all components of the service as required by CMS.

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.

Supervision of more than four concurrent procedures is based on three base units per procedure. An additional time unit may be recognized if there is documentation that the physician was present at induction.

Reimbursement for Certified Registered Nurse Anesthetist (CRNA) Services

The Plan will utilize the anesthesiology base unit and conversion factor values when calculating CRNA payment rates. See the modifiers and reimbursement rates for CRNAs in the Applicable Coding and Billing Guidelines section of this policy.

Monitored Anesthesia Care
Monitored anesthesia care (MAC) is reported with HCPCS Level II Modifiers G8, G9, or QS. MAC involves the intra-operative monitoring by a physician or qualified individual under the medical direction of a physician or of the patient's vital physiological signs in anticipation of the need for administration of general anesthesia or of the development of adverse physiological patient reaction to the surgical procedure. It also includes the performance of a pre-anesthetic examination and evaluation, prescription of the anesthesia care required, administration of any necessary oral or parenteral medications and provision of indicated postoperative anesthesia care.

The Plan pays for reasonable and medically necessary monitored anesthesia care services on the same basis as other anesthesia services.

Multiple Procedures
Anesthesiologists bill for the anesthesia services associated with multiple bilateral surgeries by reporting the anesthesia procedure with the highest base unit value with the multiple procedure modifier 51. The total time for all procedures should be reported in the line item with the highest base unit value. Only the anesthesia procedure with the highest base unit is reimbursed.

Refer to the Plan's reimbursement policy, *Bilateral and Multiple Procedure Reductions - Professional*, *WSMA 4.24* for all other multiple services rendered by anesthesiologists.

Bundled Anesthesiology Services
The Plan utilizes CMS NCCI clinical coding edits. These guidelines identify which services are included in the allowance for the primary procedure. In addition to any of the NCCI edits, the following reimbursement rules apply to anesthesia payments.

Not Separately Reimbursed Services
The following services are considered inclusive to the fees paid to the provider for other anesthesia or surgical care, unless stated otherwise in this policy:

- Field avoidance
- Local anesthesia
- Any anesthesia services performed by the physician who also performs the medical or surgical procedure.
- Psychiatrist's performance of an anesthesia service associated with the electroconvulsive therapy if the psychiatrist performs both procedures
- Pre-anesthetic examination of a patient and pre- or post-operative visits since these are included in the payment for anesthesia administration
- Preparation and monitoring services, except for those services identified in this policy
- Postoperative pain consultations when performed on the same date of service as the surgical procedure

Pain Management
The Plan follows CMS and NCCI guidelines related to pain management services.

Normal postoperative pain management, including management of intravenous patient controlled analgesia, is considered part of the surgical global package and should not be separately reported. Hospital visits or consultative services are reportable by the anesthesiologist during the postoperative period when medically necessary.

When provided mainly for postoperative pain control, peripheral nerve injections and neuraxial (spinal, epidural) injections can be separately reported on the day of surgery using the appropriate CPT procedure with a Distinct Procedural Service modifier and one unit of service. These services should not be reported on the day of surgery if they constitute the surgical anesthetic technique even if they also provide postoperative pain management.

When continuous infusion codes are reported on the day of surgery, no additional reporting of daily management is permitted on the day of catheter placement. Subsequent to the day of placement, catheter and infusion management can be reported using the appropriate visit code.

Daily hospital management of continuous epidural or subarachnoid drug administration may be reported on the first and subsequent postoperative days as medically necessary, limited to one unit of service daily.

Service Limitations

The following services are not payable:

- Anesthesia complicated by utilization of total body hypothermia
- Anesthesia complicated by utilization of controlled hypotension
- Anesthesia for patient of extreme age, under one year or over seventy
- Anesthesia complicated by emergency conditions
- Standby anesthesia is not reimbursed since this service is not direct patient care
- Physical status modifiers are not recognized by the Plan and will not be used during claim processing activities
- Any anesthesia services rendered to support a non-covered service

No additional payment will be made for the following services:

- Services billed with modifier 23, Unusual Anesthesia
- Services billed with modifier 47, Anesthesia by Surgeon

Applicable Coding and Billing Guidelines

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.

Split Claim Billing

All related services must be reported on one claim. Subsequent related claims received after the initial claim will be denied. The initial claim must be resubmitted as a replacement claim.

Taxonomy

The Plan requires providers to submit the Medicare approved taxonomy in field locator 81 for paper claims, or the electronic equivalent. Claims submitted without the taxonomy code will be denied.

Anesthesia Billing Guidelines

The American Society of Anesthesiologists (ASA) 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 will result in denial of the procedure or service.

Anesthesia Modifiers

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

Modifier	Description	Reimbursement
AA	Anesthesia performed personally by an anesthesiologist	Reimbursement is based on 100% of the applicable fee schedule or the contracted/negotiated rate.
AD	Medically supervised by a physician for more than four concurrent procedures	Reimbursement is based on 100% of the applicable fee schedule or the contracted/negotiated rate for up to three base units for anesthesiologists.
G8	Monitored anesthesia care for deep complex, complicated, or markedly invasive surgical procedure	
G9	Monitored anesthesia care for patient who has a history of severe cardiopulmonary disease	
GC	These services have been performed by a resident under the direction of a teaching physician	
QS	Monitored anesthesia care	
QK	Medically directed by a physician: two, three, or four concurrent procedures	Reimbursement is based on 50% of the applicable fee schedule or the contracted/negotiated rate.
QX	CRNA with medical direction by a physician	Reimbursement is based on 50% of the applicable fee schedule or the contracted/ negotiated rate.
QY	Medical direction of one CRNA by an anesthesiologist	Reimbursement is based on 50% of the applicable fee schedule or the contracted/negotiated rate.
QZ	CRNA without medical direction by a physician	Reimbursement is based on 100% of the applicable fee schedule or the contracted/negotiated rate.

Policy History

Original Approval Date	Original Effective Date and Version Number	Policy Owner	Original Policy Approved by
09/21/2021	01/01/2022	Payment Policy	Payment Policy Committee

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
02/15/2022	Annual review, no changes	03/01/2022	Payment Policy Committee

Other Applicable Policies

- Bilateral and Multiple Procedure Reductions – Professional, WSMA 4.24
- General Billing and Coding Guidelines, WSMA 4.17
- General Clinical Editing and Payment Accuracy Review Guidelines, WSMA 4.18
- Physician and Non-Physician Practitioner Services, WSMA 4.28

References

- Medicare Claims Processing Manual 100-04, Chapter 12, Physician/Non-Physician Practitioners
- Centers for Medicare and Medicaid National Correct Coding Initiative Policy Manual, Chapter 2
- Centers for Medicare and Medicaid National Anesthesia Center

Disclaimer Information

Plan refers to Boston Medical Center Health Plan, Inc. which operates under the trade name WellSense Health Plan. This Policy provides information about the Plan's reimbursement/claims adjudication processing guidelines. The use of this Policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement. Member cost-sharing (deductibles, coinsurance and copayments) may apply – depending on the member's benefit plan. Unless

otherwise specified in writing, reimbursement will be made at the lesser of billed charges or the contractual rate of payment. Plan policies may be amended from time to time, at Plan's discretion. Plan policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization guidelines (including NCQA). The Plan reserves the right to conduct Provider audits to ensure compliance with this Policy. If an audit determines that the Provider did not comply with this Policy, the Plan will expect the Provider to refund all payments related to non-compliance. For more information about the Plan's audit policies, refer to the Provider Manual.