Anesthesia Services

Surgical Anesthesia

Surgical anesthesia services may be provided by an anesthesiologist or certified registered nurse anesthetist (CRNA).

Procedure codes in the 'Anesthesia' section of the *Current Procedural Terminology* (CPT) manual are used to bill for surgical anesthesia procedures.

- Reimbursement for surgical anesthesia procedures are based on formulas utilizing base units, time units (1 unit = 15 min) and a conversion factor as identified in the anesthesia fee schedule. Budget reductions will apply when applicable;
- General anesthesia services for dental procedures are reimbursed an additional $20 per time unit. To receive the additional reimbursement, modifier 23 must be appended to the anesthesia CPT code 00170, in addition to the appropriate anesthesia modifiers;
- The anesthesia fee schedule is located on the Louisiana Medicaid website at www.lamedicaid.com, under the fee schedule link; and
- Minutes **must** be reported on anesthesia claims.

A **surgeon** who performs a non-obstetrical surgical procedure will not be reimbursed for the administration of anesthesia for the procedure.

The following modifiers are used to bill for **surgical anesthesia** services:

Modifier	Servicing Provider	Surgical Anesthesia Service
AA	Anesthesiologist	Anesthesia services performed personally by the anesthesiologist
QY	Anesthesiologist	Medical direction* of one CRNA
QK	Anesthesiologist	Medical direction* of two, three, or four concurrent anesthesia procedures involving qualified individuals
QX	CRNA	CRNA service with direction* by an anesthesiologist

Modifier	Servicing Provider	Surgical Anesthesia Service
QZ	CRNA	CRNA service without medical direction* by an anesthesiologist
23	Anesthesiologist/CRNA	Unusual Anesthesia (for anesthesia procedure code 00170 only)

*See Medical Direction section for further explanation.

The following are acceptable uses of modifiers:

Modifiers which can stand alone	AA and QZ
Modifiers which need a partner	QK, QX and QY
Valid combinations	QK and QX or QY and QX
Modifier 23 (CPT code 00170 only)	In addition to modifiers above

Medical Direction

Medical direction includes:

- Performing a pre-anesthetic examination and evaluation;
- Prescribing the anesthesia plan;
- Participating personally in the most demanding procedures in the anesthesia plan, including induction and emergence;
- Ensuring that any procedures in the anesthesia plan that ~~he/she~~the anesthesiologist or CRNA does not perform are rendered by a qualified individual;
- Monitoring the course of anesthesia administration at frequent intervals;
- Remaining physically present and available for immediate diagnosis and treatment of emergencies; and
- Providing the indicated post-anesthesia care.

Only anesthesiologists are reimbursed for medical direction.

Maternity-Related Anesthesia

Maternity-related anesthesia services may be provided by anesthesiologists, CRNAs or the delivering physician. Refer to the anesthesia fee schedule on the Medicaid website, www.lamedicaid.com for reimbursement information.

Procedure codes in the 'Anesthesia Obstetric' section of the CPT manual are used to bill for maternity-related anesthesia services by anesthesiologists and CRNAs.

The delivering physician must use CPT codes in the 'Surgery Maternity Care and Delivery' section of the CPT manual to bill for maternity-related anesthesia services.

Reimbursement for these services is a flat fee, except for general anesthesia for vaginal delivery.

The following modifiers are used when billing for maternity-related anesthesia services:

Modifier	Servicing Provider	Service Performed
AA	Anesthesiologist	Anesthesia services performed personally by the anesthesiologist
QY	Anesthesiologist	Medical direction* of one CRNA
QK	Anesthesiologist	Medical direction* of two, three, or four concurrent anesthesia procedures
QX	CRNA	CRNA service with medical direction* by an anesthesiologist
QZ	CRNA	CRNA service without medical direction* by an anesthesiologist
47	Delivering Physician	Anesthesia provided by delivering physician
52	Delivering Physician or Anesthesiologist	Reduced services
QS	Anesthesiologist or CRNA	Monitored anesthesia care service The QS modifier is a secondary modifier only, and must be paired with the appropriate anesthesia provider modifier (either the anesthesiologist or the CRNA). The QS modifier indicates that the provider **did not introduce** the epidural for anesthesia, but **did monitor** the beneficiary after catheter placement.

*See Medical Direction section for further explanation.

Add-on Codes for Maternity-Related Anesthesia

When an add-on code is used to fully define a maternity-related anesthesia service, the date of delivery must be the date of service for both the primary and the add-on code.

An add-on code is not a full service and cannot be reimbursed separately to different providers unless more than one provider performs services over the duration of labor and delivery.

A group practice frequently includes anesthesiologists and/or CRNA providers. One member may provide the pre-anesthesia examination/evaluation, and another may fulfill other criteria. The medical record must indicate the services provided and must identify the provider who rendered the service.

Billing for Maternity-Related Anesthesia

- Reimbursement for maternity-related procedures, other than general anesthesia for vaginal delivery, is a flat fee; and
- Minutes **must** be reported on all maternity-related anesthesia claims.

The following chart must be followed when billing for **maternity-related anesthesia**:

Type of Anesthesia	CPT Code	Modifier	Reimbursement	Service
Vaginal Delivery General Anesthesia	01960	Valid Modifier	Formula	Anesthesiologist performs complete service, or direction of the CRNA
				CRNA performs complete service with or without direction by Anesthesiologist

Type of Anesthesia	CPT Code	Modifier	Reimbursement	Service
Epidural for Vaginal Delivery	01967	AA, QY or QK for MD QX or QZ for CRNA	Flat Fee	See modifier list for maternity-related services
Cesarean Delivery only (epidural or general)	01961	AA, QY or QK for MD QX or QZ for CRNA	Flat Fee	See modifier list for maternity-related services
Cesarean Delivery after Epidural, for planned vaginal delivery	01967 + 01968	AA, QY or QK for MD QX or QZ for CRNA	Flat Fee plus add-on	See modifier list for maternity-related services
Cesarean Hysterectomy after Epidural and Cesarean Delivery	01967 + 01969	AA, QY or QK for MD QX or QZ for CRNA	Flat Fee plus add-on	See modifier list for maternity-related services
Epidural – Vaginal Delivery	59409 59612	47	Fee for delivery plus additional reimbursement for anesthesia	Delivering physician provides the **entire** service for vaginal delivery
Epidural – Vaginal Delivery	59409 59612	47 and 52	Fee for delivery plus additional reimbursement for anesthesia	Introduction only by the delivering physician
Epidural – Vaginal Delivery	01967	AA and 52	Flat Fee	Introduction only by anesthesiologist

Type of Anesthesia	CPT Code	Modifier	Reimbursement	Service
Epidural – Vaginal Delivery	01967	AA and QS for MD QZ and QS or QX and QS for CRNA	Flat Fee	Monitoring by anesthesiologist or CRNA
Cesarean Delivery	59514 59620	47 and 52	Fee for delivery plus additional reimbursement for anesthesia	Introduction only by the delivering physician
Cesarean Delivery – after Epidural	01961	AA and 52	Flat Fee	Introduction only by the anesthesiologist
Cesarean Delivery-following Epidural for planned vaginal delivery	01967 + 01968	AA and 52	Flat Fee plus add-on	Introduction only by the anesthesiologist
Cesarean Delivery – after Epidural	01961	AA and QS for MD QZ and QS or QX and QS for CRNA	Flat Fee	Monitoring by the anesthesiologist or CRNA
Cesarean Delivery-following Epidural for planned vaginal delivery	01967 + 01968	AA and QS for MD QZ and QS or QX and QS for CRNA	Flat Fee plus add-on	Monitoring by the anesthesiologist or CRNA

Anesthesia for Tubal Ligation or Hysterectomy

Anesthesia reimbursement for tubal ligations and hysterectomies is formula-based, with the exception of anesthesia for cesarean hysterectomy (CPT code 01969).

The reimbursement for CPT codes 01967 and 01969, when billed together, is a flat fee. CPT code 01968 is implied in CPT code 01969 and should not be placed on the claim form if a cesarean hysterectomy was performed after C-section delivery.

The primary surgeon is required to complete the following forms for reimbursement of services for sterilizations and hysterectomies. The primary surgeon shall share the forms with all ancillary providers involved in the beneficiary's care (e.g. hospital, anesthesiologist, assistant surgeon, and/or ambulatory surgery center).

- Sterilization: Form OMB No. 0937-0166/HHS-687, "Consent for Sterilization"; and

- Hysterectomy: Form 96-A, "Acknowledgement of Receipt of Hysterectomy Information."

If an ancillary provider submits a claim for sterilization or hysterectomy services without the appropriate consent form, the claim will be paid only if the primary surgeon's claim has been approved.

The ancillary provider's claim may be held for up to 30 days pending review of the primary surgeon's claim. If the primary surgeon's claim has not been approved during this timeframe, Medical Review will deny the ancillary provider's claim. If the claim is denied, ancillary providers may resubmit after allowing additional time for the primary surgeon's claim to be paid or submit the claim, in hard-copy, with the appropriate consent form.

Pediatric Moderate (Conscious) Sedation

Claims for moderate sedation should be submitted hard copy indicating the medical necessity for the procedure. Documentation should also reflect pre-sedation and post-sedation clinical evaluation of the beneficiary.

Moderate sedation does not include minimal sedation (anxiolysis), deep sedation or monitored anesthesia care.

Moderate sedation is restricted to beneficiaries from birth to age 13. Exceptions to the age restriction will be made for children who have severe developmental disabilities with documentation attached to support this condition. No claims will be considered for beneficiaries 21 years of age or older.

Moderate sedation includes the following services (which are not reported/billed separately):

- Assessment of the beneficiary (not included in intra-service time);
- Establishment of intravenous (IV) access and fluids to maintain patency, when performed;
- Administration of agent(s);
- Maintenance of sedation;
- Monitoring of oxygen saturation, heart rate and blood pressure; and
- Recovery (not included in intra-service time).

Intra-service time starts with the administration of the sedation agent(s), requires continuous face-to-face attendance, and ends at the conclusion of personal contact by the physician providing the sedation.

Louisiana Medicaid has adopted CPT guidelines for all moderate sedation services and procedures that include moderate sedation as an inherent part of providing the procedure.

Louisiana Medicaid will reimburse a second physician other than the health care professional performing the diagnostic or therapeutic, when the second physician provides moderate sedation in the facility setting (e.g., hospital, outpatient hospital, ambulatory surgical center, skilled nursing facility); however, moderate sedation services performed by a second physician in the non-facility setting (e.g., physician office, freestanding imaging center) should not be reported.

Pain Management

Epidurals that are administered for the prevention or control of acute pain, such as that which occurs during delivery or surgery, are covered by the Professional Services Program for this purpose only.

~~**Epidurals given to alleviate chronic, intractable pain are not covered.**~~**Chronic Pain**

Coverage for chronic intractable pain is dependent on the clinical etiology and the type of service or treatment.

If a beneficiary requests treatment for chronic intractable pain, depending on the underlying cause or anatomical defect, the provider may determine treatment or management to include:

- Physical therapy;
- Occupational therapy;
- Medication therapy management (MTM);
- Epidural steroid injection (ESI) therapy;
- Acupuncture;
- Chiropractic;
- Behavioral health; and/or
- Addiction medicine services in coordination with case management.

These include some alternative treatments and the inclusion of coverage on the Professional Services Fee Schedule to define covered treatments.

Certain Medicaid procedures or services may require prior authorization. Procedure codes requiring prior authorization can be identified on the Professional Services Fee Schedule.

Note: Medical Necessity for epidural steroid injection (ESI)ESI shall be determined by the history of illness, physical examination, and concordant diagnostic imaging supporting radiculopathy, radicular pain, or neurogenic claudication due to herniation, stenosis, and/or degenerative disease protracted and severe enough to greatly impact quality of life or function. If a beneficiary requests treatment for chronic intractable pain, the provider may submit a claim for the initial office visit. Subsequent services that are provided for the treatment or management of this chronic pain are not covered, and are billable to the beneficiary. Claims paid inappropriately are subject to recoupment.

Claims Filing

Anesthesia claims may be submitted either electronically or hard copy, using the CMS 1500 claim form.

Dental

Anesthesia for dental restoration should be billed under the appropriate CPT anesthesia code with the appropriate modifier, minutes and most specific diagnosis code.

Anesthesia Time

Anesthesia time begins when the provider begins to prepare the beneficiary for induction and ends with termination of the administration of anesthesia. Time spent in pre- and postoperative care may not be included in the total anesthesia time.

Group Practices

If the billing provider is a group practice that includes multiple anesthesiologists and/or CRNAs, one member may provide the pre-anesthesia examination/evaluation and another may fulfill other criteria. The medical record must indicate the services provided and must identify the provider who rendered the service.

Multiple Surgical Procedures

Anesthesia for multiple surgical (non-OB) procedures in the same anesthesia session must be billed on one claim line using the most appropriate anesthesia code with the total anesthesia time spent reported in item 24G on the claim form.

The only secondary procedures that are not billed in this manner are tubal ligations and hysterectomies.

The following claims **require a hard-copy** and special instructions:

- ***Claims with a total anesthesia time of less than 10 minutes or greater than 224 minutes*.** Submit a hard copy claim with the appropriate anesthesia graph attached;

- ***Claims for multiple but separate operative services performed on the same beneficiary on the same date of service***;

  NOTE: Submit a hard-copy claim with a cover letter explaining the circumstances and medical necessity. Attach anesthesia graphs from surgical procedures to the fiscal intermediary's Provider Relations Unit.

- ***Anesthesia for vaginal procedures, hysteroscopy, and/or hysterosalpingogram (HSG)***;

  NOTE: Claims will pend to Medical Review and must have anesthesia record attached.

- The attached documentation must indicate the following:
    - Medical necessity for anesthesia (diagnosis of mental retardation, hysteria, and/or musculoskeletal deformities that would cause procedural difficulty); and
    - HSG meets the criteria for that procedure (Refer to the 'Medical Review' section).

- **V*aginal Delivery – Complete Anesthesia Service by Delivering Physician***; and

  NOTE: The delivering physician should submit a claim for the delivery and anesthesia on a single claim line with modifier 47. The fee for the delivery plus the additional reimbursement will be paid for both services in a single payment.

- ***Claims that deny with error codes 749 (delivery billed after hysterectomy was done) or 917 (lifetime limits for this service have been exceeded)***.

  NOTE: A new claim must be submitted to the fiscal intermediary's Provider Relations Unit with a cover letter explaining the situation that caused the original claim denial**.**