COMMUNITY Health Options

Anesthesia Professional

Reimbursement Policy

Purpose

To provide an outline of anesthesia professional fee billing requirements and guidelines for appropriate payment consideration.

Definitions

- **Qualified nonphysician anesthetists**: used to refer to both certified registered nurse anesthetists (CRNAs) and anesthesiologists' assistants unless otherwise separately discussed.
- **Anesthesia professional services**: Current Procedural Terminology (CPT) codes in the range 00100-01999 and are reimbursed as time-based using the Standard Anesthesia Formula. CPT codes 01953 and 01996 are excluded and should not be reported as time-based services.

Policy

Community Health Options (Health Options) utilizes various resources for the reimbursement of anesthesia professional services, including but not limited to the following:

- American Medical Association Current Procedure Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) rules, including modifiers
- American Society of Anesthesiologists (ASA) Relative Value Guide (RVG)
- Centers for Medicare & Medicaid Services (CMS) guidelines as stated in manuals, transmittals, articles, etc.
- CMS National Correct Coding Initiative (NCCI)
- CMS National Physician Fee Schedule

Anesthesia professional fees are required to be billed using the 1500 Health Insurance Claim Form (aka. CMS-1500) or its electronic equivalent. "All claims forms must have the provider billing number of the qualified nonphysician anesthetist and/or the employer of the qualified nonphysician anesthetist performing the service in either block 24.H of the Form CMS-1500 and/or block 31 as applicable" (CMS Manual System).

Anesthesia Time Units

Anesthesia time is required in the 'days or units' (Section 24G) of the CMS-1500 form. Consistent with CMS guidelines, Community Health Options requires that one-minute increments of actual anesthesia time be reported on the claim, one-minute per unit. "Anesthesia time means the time during which a qualified nonphysician anesthetist is present with the patient. It starts when the qualified nonphysician anesthetist begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ends when the qualified nonphysician anesthetist is no longer furnishing anesthesia services to the patient, that is, when the patient may be placed safely under postoperative care. Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service" (Medicare Claims Processing Manual, Chapter 12). Health Options will calculate time units by dividing billed anesthesia minutes by 15 and round up to the nearest whole number. For example:

43 minutes of anesthesia billed / 15-minute increment = 2.866 units

2.866 would round to 3.0-time units

Modifiers

Anesthesia professional fee services are required to be submitted with one of the required anesthesia modifiers, as defined below, in the first modifier position of the claim form.

Required Anesthesia Modifiers	Definition	Reimbursement Percentage of Allowed Amount
AA	Anesthesia services performed personally by anesthesiologist	100%
AD	Medical supervision by a physician: more than four concurrent anesthesia procedures	100%
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals	50%
QX	CRNA service: qualified nonphysician anesthetist with medical direction by a physician	50%
QY	Medical direction of one qualified nonphysician anesthetist by an anesthesiologist	50%
QZ	CRNA service: without medical direction by a physician	100%

Risk Modifiers

Risk modifiers are required to be submitted in the second modifier field of the claim form. Risk modifier reimbursement applies only when the primary modifier is 'AA' as personally performed by the anesthesiologist or employed CRNA. Appending a physical status modifier to a time-based anesthesia code identifies the level of complexity for the most complex situations.

P-3 Patient with sever systemic disease, such as uncontrolled diabetes or hypertension requiring medication.
P-4 Patient with sever systemic disease that is a constant threat to life, such as severe respiratory or cardiac disease.
P-5 Moribund patient who is not expected to survive without the operation, such as multiple severe trauma or severe head injury.
(P1, P2, and P6 are not recognized for reimbursement purposes)

Reimbursement Formulas

1. Modifiers AA, QK, QX, QY, QZ: ([Base Unit Value* + Time Units + Modifying Units] x Contracted Conversion Factor) x Modifier Percentage
2. Modifier AD: ([Base Unit Value of 3 + 1 Additional Unit if medical records/anesthesia notes indicate the physician was present during induction] x Contracted Conversion Factor) x Modifier Percentage

*Health Options uses the current American Society of Anesthesiologists (ASA) Base Units, as published in the ASA Relative Value Guide (RVG) in effect on the date of service.

Conclusion

Health Care providers (facilities, physicians, and other health care professionals) are responsible for accurately and timely: documenting, billing, and coding by following CMS billing guidelines for appropriate claims review processing by Community Health Options.

Payment for services furnished by qualified nonphysician anesthetists are subject to member eligibility, prior authorization of services, coinsurance, and deductibles.

References

CMS Manual System, Pub 100-04 Medicare Claims Processing, Transmittal 3747: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2017Downloads/R3747CP.pdf

Medicare Claims Processing Manual, Chapter 12, Section 140.3.2: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

Document Publication History

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This policy provides information on Community Health Options' claims adjudication processing guidelines. As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, adherence to plan policies and procedures, and claims editing logic. Community Health Options reserves the right to amend a payment policy at its discretion. Policies are enforced unless underpinning direction stated otherwise.