Health Partners of Philadelphia, Inc.

Anesthesia Billing Guide

Introduction

Health Partners of Philadelphia, Inc. does business as **Health Partners** (Medicaid) and **Senior Partners** (Medicare). Health Partners of Philadelphia, Inc., is required by State and Federal regulations to capture specific data regarding services rendered to its members. This manual is intended to help providers submit this data so that the data collection requirements can be met.

This billing guide is designed to provide Health Partners providers (for both lines of business – Medicaid/Health Partners and Medicare/Senior Partners) with current policy, billing criteria, and reimbursement information for anesthesia services, medical direction of anesthesia, and services of a certified registered nurse anesthetist (CRNA). This billing guide should be used when reporting anesthesia and CRNA services. This guide is only applicable to anesthesia services; it does not include pain management services.

Administration of Anesthesia

The following types of anesthesia are eligible for separate reimbursement by Health Partners and Senior Partners:

- Inhalation
- Regional
  - spinal (low spinal, saddle block)
  - epidural (caudal)
  - nerve block (retrobulbar, brachial plexus block, etc.)
  - field block
- Intravenous
- Rectal
- Local anesthesia
- Standby anesthesia (99360)

The following types of anesthesia services are **not eligible** for separate reimbursement:

- Anesthesia provided in conjunction with non-covered services
- Administration of anesthesia by the surgeon or assistant surgeon

Note: Payment for the anesthesia service is made through the payment for the medical or surgical service.

All claims reporting the administration of anesthesia must include the following:

- The appropriate anesthesia procedure code (00100 - 01999)
- Anesthesia time (units and time)
- The appropriate anesthesia modifier to identify the professional(s) who rendered the service

Anesthesia Procedure Codes
Procedure codes 00100 - 01999 should be used to report the administration of anesthesia. Additional units are not recognized for the patient's age, physical status, or unusual risk factors,

including hypothermia, hypotension, or emergency circumstances. Because 01999 is considered a not otherwise classified code, a complete description of the service should be reported.

Anesthesia Add-on-codes

Health Partners and Senior Partners will cover the following anesthesia add-on-codes involving burn excisions or debridement and obstetrical anesthesia. The add-on-code is billed in addition to the primary anesthesia code. All anesthesia time should be submitted with the primary anesthesia code, with the exception of add-on obstetrical codes, along with the appropriate anesthesia modifier to identify who rendered the service.

- The appropriate primary anesthesia burn or debridement procedure code 09152
- The appropriate anesthesia add-on code 01953
- Anesthesia time (time units)
- The appropriate anesthesia modifier to identify who rendered the service
- The appropriate primary anesthesia obstetrical procedure code 01967
- The appropriate anesthesia add-on code 01968 or 01969
- Anesthesia time (in total minutes) for both the primary and add-on code(s) 01968 or 01969
- The appropriate anesthesia modifier to identify who rendered the service

For additional information on modifier reporting, please refer to the **Modifier** section of this billing guide.

Base Units

Base unit values have been assigned to each anesthesia procedure code, according to ASA standards, which reflect the difficulty of the anesthesia service, including the usual pre-operative and post-operative care and evaluation.

For the following obstetrical anesthesia codes, Health Partners has increased the base units by 4 units above the ASA standards: 01960, 01961, 01962, 01963, and 01967.

Do not report base units on your claim submissions. Health Partners' and Senior Partners' processing system automatically determines the base units based on the reported procedure code and modifiers.

Time Units

Anesthesia time is the time during which an anesthesia practitioner is present with the patient. Anesthesia practitioner is defined as a physician who performs the anesthesia service alone, a CRNA who is not medically directed, or a CRNA, who is medically directed. The physician who medically directs the CRNA or would ordinarily report the same time as the CRNA or reports for the CRNA service.

Anesthesia time starts when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room or the 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. Anesthesia time is a continuous time period for the start of anesthesia to the end of an anesthesia service.

The anesthesia practitioner can add blocks of time around an interruption in anesthesia time as long as the anesthesia practitioner is furnishing continuous anesthesia care within the time

periods around the interruption.

Time units are determined on the basis of one time unit for each 15 minutes of anesthesia. Providers should report the total anesthesia time units on the claim. If fractional units are submitted, Health Partners and Senior Partners will round to the nearest whole number of units.

Note: Time units are not recognized for codes 01995 (regional IV administration of local anesthetic agent upper or lower extremity) and 01996 (daily management of epidural or subarachnoid drug administration).

Locum Tenens

Locum Tenens (LT) physicians may only provide *substitute* services for a maximum of 60 continuous days. Claims for LT services beyond this time frame will be denied.

Claims for LT anesthesiologists must be presented under the regular anesthesiologist's Provider Identification number. Each procedure code submitted must have an AA modifier in the first position and a Q6 modifier in the second position, identifying a LT physician service.

Locum Tenens may not be used to expand the staffing of an anesthesiology practice. Physicians added to the staff must submit applications for participation.

Modifiers
One of the following anesthesia procedure code modifier(s) must be reported to identify who rendered the anesthesia service. **Claims without one of the following modifiers will not be paid:**

AA Anesthesia services performed personally by anesthesiologist
AD Medically supervised by a physician for more than four concurrent procedures
QK Medically directed by a physician: two, three, or four concurrent procedures
QX CRNA with medical direction by a physician
QY Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist
QZ CRNA without medical direction by a physician

The following modifiers should be reported in the 2nd position under appropriateness of the modifier to the code:

QS Monitored anesthesia care service
23 Unusual anesthesia [When using modifier 23, appropriate documentation must be submitted with the claim.]

Monitored Anesthesia Care
Monitored anesthesia care (MAC) involves the intra-operative monitoring 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. MAC 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 (e.g., atropine, demerol, valium) and provision of indicated postoperative anesthesia care.

Monitored Anesthesia Care (MAC) requires careful and continuous evaluation of various vital physiological functions and the diagnosis and treatment of any clinical observations or deviations.

MAC can be provided by a variety of qualified anesthesia personnel. However, such personnel must have training and experience involving:

- patient assessment
- continuous evaluation and monitoring of patient physiological functions
- diagnosis and treatment (both pharmacological and non-pharmacological) of any and all deviations in physiological functions.

Also, adequate medical and pharmacological equipment must be readily available at all times during MAC.

Coverage for MAC is allowed only when all of the following are satisfied:

- the service is properly coded;
- documentation is clear and all documentation requirements are met; and
- the service is reasonable and necessary.

a. Coverage
MAC must be provided by qualified anesthesia personnel. These individuals must be continuously present to monitor the patient and provide anesthesia care.
During MAC, the patient's oxygenation, ventilation, circulation and temperature should be evaluated by whatever method is deemed most suitable by the attending anesthetist. Close monitoring is necessary to anticipate the need for general anesthesia administration or for the treatment of adverse physiologic reactions such as hypotension, excessive pain, difficulty breathing, arrhythmias, adverse drug reactions, etc. In addition, the possibility that the surgical procedure may become more extensive, and/or result in unforeseen complications, requires comprehensive monitoring and/or anesthetic intervention.

During monitored anesthesia care, the attending anesthetist must provide a number of specific services, including but not limited to all of the following:

- Pre-procedure visit and evaluation
- Intra-procedure monitoring of patient's vital signs, maintenance of the patient's airway and continual evaluation of vital functions
- Diagnosis and treatment of any clinical problems which occur during the procedure
- Administration of sedatives, analgesics, hypnotics, anesthetic agents or other medications as necessary to ensure patient safety and comfort
- Provision of medical services as needed to accomplish the safe completion of the procedure
- Post-procedure anesthesia management

b. Facility-Equipment Requirements
The following facility and equipment requirements encourage quality patient care, but observing them cannot guarantee any specific patient outcome.

- MAC location must have a reliable source of oxygen adequate for the length of the procedure. There must also be a backup supply.
- MAC location must have an adequate and reliable source of suction. Suction apparatus that meets operating room standards is encouraged.

- MAC locations in which inhalation anesthetics are administered must have an adequate and reliable system for scavenging waste anesthetic gases
- Each MAC location must include:
    1) a self-inflating hand resuscitator bag capable of administering at least 90 percent oxygen as a means to deliver positive pressure ventilation;
    2) adequate anesthesia drugs, supplies and equipment for the intended anesthesia care, and
    3) adequate monitoring equipment to allow for all patient monitoring noted in documentation requirements.
    4) Each MAC location shall have immediately available an emergency cart with defibrillator, emergency drugs and other equipment adequate to provide cardiopulmonary resuscitation.

c. Requirements
Health Partners and Senior Partners requirements for this type of anesthesia are the same as for general anesthesia. Specifically, the requirement includes the performance of pre-anesthetic examination and evaluation, prescription of the anesthesia care required, the completion of the anesthesia record, the administration of necessary oral or parenteral medications and the provision of indicated post-operative anesthesia care. Appropriate documentation must be available to reflect the pre and post-anesthetic evaluations and intraoperative monitoring.

Reimbursement for MAC will be the same amount allowed for full general anesthesia services if all the requirements listed under these indications are met. The provision of quality MAC is mandatory and requires the same expertise and the same effort (work) as required in the delivery of a general anesthetic. If the requirements are not fulfilled or the procedures are unnecessary, payment will be denied in full.

The MAC service rendered must be reasonable, appropriate and medically necessary. The presence of an underlying condition alone, as reported by an ICD-9 code, may not be sufficient evidence that MAC is necessary. The medical condition must be significant enough to impact the need to provide MAC such as the patient being on medication or being symptomatic, etc. The presence of a stable, treated condition in and of itself is not necessarily sufficient.

d. MAC Reporting
When reporting MAC, always append the modifier:
QS - monitored anesthesia care service

Note: The QS modifier should always be reported in the second position. For additional modifier reporting, refer to **Modifier** section of the billing guide.

Always report the appropriate ICD-9 code(s) that:
1) Supports the medical necessity for the MAC, and
2) Identifies the reason for the surgical procedure.

e. Documentation
Clear and complete documentation is a factor in the provision of quality care. Supportive documentation is the responsibility of the anesthetist, and mandatory for Health Partners and Senior Partners coverage and reimbursement. While anesthesia care is a continuum, it is viewed as consisting of preanesthesia, perianesthesia and postanesthesia components. Monitored anesthesia care (MAC) must be documented to include the following:

Pre-anesthesia evaluation
A. Patient interview to include medical history, anesthesia history, medication history
B. Appropriate physical exam
C. Review of objective diagnostic data (e.g., laboratory, ECG, X-ray)
D. Assignment of physical status (e.g., ASA physical status protocols)
E. Formulation and discussion of an anesthesia plan with the patient (and/or responsible adult) and patient's attending surgeon

Perianesthesia (time-based record of events)
A. Immediate review prior to initiation of anesthetic procedure:
1. Patient re-evaluation
2. Check of equipment, drugs, gas supply
B. Monitoring of the patient
1. Qualified anesthesia personnel shall be present in the room throughout MAC
2. The patient's oxygenation, ventilation, circulation, and temperature shall be continually evaluated.
C. Amounts of all drugs and agents used, and times given
D. The type and amounts of any/all intravenous fluids used, including blood and blood products, and times given
E. The technique(s) used
F. All unusual events during the anesthesia-monitoring period
G. Status of patient at conclusion of anesthesia and procedure

Post-anesthesia
A. Patient evaluation on admission and discharge from post-anesthesia
B. A time-based record of vital signs and level of consciousness
C. All drugs administered and their dosages
D. Types and amounts of intravenous fluids administered
E. Any unusual events including post-anesthesia or post-procedural complications
F. Post-anesthesia visits and any follow-up prescribed

The presence of an underlying condition alone, as reported by an ICD-9 code, may not be sufficient evidence that MAC is necessary. The medical condition must be significant enough to impact the need to provide MAC and be clearly reflected in the medical record.

- The following indications/conditions will be reviewed on an individual consideration basis. Documentation to support the medical necessity of the service must be submitted with the claim.
  - Combative patients
  - Patients with low pain thresholds or who suffer severe pain
  - Intraoperative expansion of procedure
  - Any condition in a Health Partners or Senior Partners eligible pediatric patient
  - Mental retardation (e.g., patients who are uncooperative due to a lack of understanding caused by their mental disability)
  - The administration of certain anesthetic drugs that require the expertise of an anesthesiologist/CRNA (e.g., propofol)

Medical Direction
The personal medical direction by a physician of a qualified anesthetist, i.e., certified registered nurse anesthetist (CRNA) may be paid if the following criteria are met:

- Not more than four anesthesia procedures are being performed concurrently;
- The physician is physically present in the operating suite;
- Medical direction is a covered service only if:
    - the physician performs a pre-anesthetic examination and evaluation;
    - the physician prescribes the anesthesia plan;
    - the physician must personally participate in the most demanding procedures of the anesthesia plan, including, if applicable induction and emergence;
    - the physician ensures that a qualified individual performs any procedures in the anesthesia plan that he or she does not perform;
    - the physician monitors the course of anesthesia administration at frequent intervals;
    - the physician remains physically present and available for immediate diagnosis and treatment or emergencies; and
    - the physician provides indicated post-anesthesia care.
- The physician does not perform any other services (except as noted below) during the same time period. The physician directing the administration of not more than four anesthesia procedures may provide the following without affecting the eligibility of his/her medical direction services:
    - address an emergency of short duration in the immediate area;
    - administer an epidural or caudal anesthetic to ease labor pain;
    - provide periodic, rather than continuous, monitoring of an obstetrical patient;
    - receive patients entering the operating suite for the next surgery;
    - check or discharge patients in the recovery room; or
    - handle scheduling matters.

When billing for medical direction of anesthesia procedures use the following modifiers:

- The physician should report the QK (Medically directed by a physician; two, three, or four concurrent procedures).
- The CRNA should report the QX (CRNA with medical direction by a physician).

Concurrent medical direction refers to involvement of the anesthesiologist in directing two, three, or four concurrent anesthesia procedures. Concurrency is defined as the maximum number of procedures that the physician is medically directing within the context of a single procedure and whether those other procedures overlap each other. Concurrency is not dependent on each of the cases involving a Health Partners or Senior Partners patient. In other words, if three procedures are medically directed, two of which involve Health Partners or Senior Partners patients, the Health Partners or Senior Partners claims should be billed as concurrent medical direction of three procedures.

In addition to certifying the number of anesthetists concurrently directed, the anesthesiologist must have on file each procedure performed and the name of each anesthetist directed. Documentation of this requirement must be maintained in the patient's medical record and available to Health Partners upon request.

If the anesthesiologist is involved in more than four concurrent procedures, the anesthesiologist's services are considered supervisory in nature and should be reported with the AD modifier (medically supervised more than four concurrent procedures). Health Partners and Senior Partners will reimburse the anesthesiologist for supervisory services at the allowance rate of three base units per procedure.

An additional time unit can be recognized if the physician can document his or her presence at induction. To document presence at induction, report BOTH modifiers **AD and 23.**

Medical Direction of One
Effective for dates of service on or after July 1, 2004, Heath Partners' payment policy allows reimbursement for medically directed services when only one service is supervised. The payment amount for the physician service and the CRNA service is fifty percent of the allowance otherwise recognized had the service been furnished by the anesthesiologist alone.

When the CRNA and the anesthesiologist are involved in a single case and the physician is performing medical direction, submit the services using the following modifiers:

- For single medically directed services, the physician reports the QY modifier.
- The CRNA reports the QX modifier to indicate medical direction.

Anesthesia Procedure Personally Performed by the Physician
Use of a AA modifier should be reported when either of the following occurs:

- The physician personally provides the entire anesthesia service.
- The physician and an anesthetist are both completely and fully involved in a single anesthesia service (refer to the Medical Direction of One section).

Any circumstances other than those listed above are considered to be medical direction and should be reported as such.

Use the AA modifier to report anesthesia services performed personally by anesthesiologist.

Anesthesia Services and Teaching CRNAs
Payment may be made to an instructor who is an anesthesiologist and who is continuously present when a student nurse anesthetist provides a medical or surgical service.
Additionally, payment may be made to a teaching CRNA who supervises a single case involving a student nurse anesthetist where the CRNA is continuously present. In this instance, the CRNA reports the service using the "QZ" modifier. This modifier designates that the teaching CRNA is not medically directed by an anesthesiologist. No payment is made under Part B for the service provided by a student nurse anesthetist.

The teaching CRNA must document his/her involvement in cases with student nurse anesthetists. The documentation must be sufficient to support the payment of the service and must be made available for review upon request.

One-on-One Anesthesia, Unusual Circumstances
In unusual circumstances, i.e., complicated trauma case, in which it is medically necessary for both the CRNA and the anesthesiologist to be involved completely and fully in a single case, full payment to each can be made if documentation is submitted by both the CRNA and the anesthesiologist to support payment of the full fee for each. Claims should be submitted using the following modifiers:

- The physician should report the AA (Anesthesia services performed personally by anesthesiologist).

- The CRNA should report using the QZ (CRNA without medical direction by a physician).

Payment may be made for both the anesthetist and the anesthesiologist in the following situations:

- Cases involving trauma (This can be identified by an ICD9 diagnosis code in the range of 800.0-929.9 or 940.0-959.9).
- Ruptured aneurysms (This can identified by one of the following ICD9 diagnosis codes: 430, 441.1. 441.3, 441.5, 441.6).
- Unstable surgical patients who require massive blood transfusions (e.g., 10 units).
- Patients undergoing surgery for major body burns (>27% of body surface area. This can be identified by one of the following ICD9 diagnosis codes; 948.2-948.9).
- Pediatric and neonatal congenital heart surgery.
- Organ transplantation procedures (procedure codes 00580, 00796, 00868).

Any situation other than those above may be paid on an individual consideration basis only when the operative report and anesthesia record are submitted that document that it was medically necessary for both the anesthesiologist and the anesthetist to be involved.

Payment Calculations

Payment for the administration of anesthesia is based on the base unit value assigned to the procedure code, plus time units, multiplied by the fee schedule anesthesia conversion factor.

Payment for both the physician medical direction and the medically directed CRNA is determined by the specified percentage amount of the allowance recognized for the anesthesia procedure as if it was personally performed by the physician alone.

Anesthesia for Multiple Surgical Procedures

Payment can be made for anesthesia associated with multiple surgical procedures. Reimbursement is determined by the base unit of the anesthesia procedure with the highest base unit value and the total time units based on the actual anesthesia time of the multiple procedures.

When billing, report the anesthesia procedure code with the highest base unit value. Indicate the total time for all procedures.

Example: Multiple Procedures, Same Operative Session

Procedures	Modifier	Base Units	Time Units
00810 (45835) 09:00 – 9:25	AA	6	2.
00820 (45820)	AA	5	3

09:25 to 10:10			

Submit As:

Procedures/Time Units			
00810 45835 and 45820 9:00 to 10:10	AA		5

Administration of Anesthesia in Addition to Medical and Surgical Services

The following medical and surgical services are eligible for separate payment either furnished in conjunction with the anesthesia procedure or as a separate service, provided they are medically necessary and not precluded by the Correct Coding Initiative (CCI) (*). The payment of these procedures is based on the Health Partners and/or Senior Partners fee schedule. Time is not a consideration in reimbursing these procedures and should not be reported:

- Swan-Ganz catheter insertion (code 93503)
- Central venous pressure (CVP) line insertion (36556)
- Intra-arterial lines (codes 36620, 36625)
- Emergency intubation (code 31500)
- Critical care visits (codes 99291, 99292)
- Transesophageal echocardiography (code 93312)

Aborted Anesthesia Procedure

When surgery is aborted after general or regional anesthesia induction has taken place, payment may be made based on three base units plus time. Report this situation using unlisted procedure code 01999. The planned surgical procedure code may be requested for review.

Obtaining a Health Partners Provider Number

If you are not a Health Partners participating provider, you will need a non-participating provider number to bill. To obtain this number, please contact the Provider Helpline at: 215-991-4290. You will need to submit all of the following information to obtain this number. :

- W-9 Tax form
- UPIN #
- Medicare #
- Medicaid #
- State Medical License #
- Social Security #
- DEA #
- Specialty
- Copy of the claim

Please note: all non-emergent services by a non-participating provider require a prior authorization to be paid.

Health Partners/Senior Partners EDI Claims Submission Information

As per the Health Insurance Portability and Accountability Act of 1996 (HIPAA), all transactions and code sets must be in HIPAA standard format (ASCX12N). To assist you with compliance efforts the 837 transaction companion guides are available through the Health Partners website at http://www.healthpart.com/HIPAA.asp.

If you are not submitting your own claims, please forward the Guide to your clearinghouse or other entity responsible for your transactions. If you have any questions please contact our Provider Helpline at 215-991-4290 or 888-991-9023. EDI inquiries may also be submitted at http://www.healthpart.com/edi-inquiry_claim.asp.