Anesthesia Services

Policy

Mass General Brigham Health Plan reimburses participating providers for the administration of general and regional anesthesia and supportive services performed in conjunction with covered obstetrical, surgical, and medical procedures for optimal anesthesia care to the member.

The following payment policy does not apply to anesthesia performed with acupuncture. Please refer to the Acupuncture Services Payment Guidelines for further information.

Policy Definition

Reimbursement is made for the provision of regional or general anesthesia services provided by an anesthesiologist and supervision and/or direction of CRNA (certified registered nurse anesthetists) by an anesthesiologist.

Reimbursement

Providers are reimbursed according to the plan's network provider reimbursement or contracted rates. Claims are subject to payment edits that are updated at regular intervals.

Covered services are defined by the member's benefit plan. The manner in which covered services are reimbursed is determined by the Mass General Brigham Health Plan Payment Policy and by the provider's agreement with Mass General Brigham Health Plan. Member liability amounts may include, but are not limited to, copayments, deductible, and/or co-insurance, and will be applied dependent upon the member's benefit plan.

Various services and procedures require referral and/or authorization. Referral and authorization requirements can be located here.

Please reference procedure codes from the current CPT, HCPCS Level II, and ICD-10-CM manuals, as recommended by the American Medical Association (AMA), the Centers for Medicare & Medicaid Services (CMS), and the American Hospital Association. CMS and the AMA revise HIPAA medical codes on a pre-determined basis, including changes to CPT, HCPCS, and ICD-10 codes and definitions.

Please refer to the CMS or CPT guidelines for requisite modifier usage when reporting services. The absence or presence of a modifier may result in differential claim payment or denial.

Mass General Brigham Health Plan reviews claims to determine eligibility for payment. Services considered incidental, mutually exclusive, integral to the primary service rendered, or part of a global allowance, are not eligible for separate reimbursement. Please refer to Coding Provider Payment Guidelines for more information.

All claims are subject to audit services and medical records may be requested from the provider.

Mass General Brigham Health Plan uses the American Society of Anesthesiologists (ASA) anesthesia codes and base unit system to calculate professional reimbursement. Please refer to CMS Anesthesiologists Center for more information and to retrieve base units. The ASA updates its anesthesia base units annually.

Mass General Brigham Health Plan calculates anesthesia reimbursement by adding the ASA base value for the primary procedure to the number of units (total minutes divided by 15-minute intervals) multiplied by the conversion factor. Please refer to the calculation formula below:

- (Anesthesia Base Units as defined by ASA + Time Units as reported by the Provider) X Conversion Factor = Payment

Limitations

Pre-anesthesia Evaluation and Management (E/M) services are included in the primary anesthesia code, unless no anesthesia services are provided. If a surgery does not occur the pre-operative visit is reimbursed based on a CPT evaluation and management code.

Anesthesia services comprise anesthesia care during the procedure, the administration of fluids and/or blood and the usual monitoring services including: ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry.

Definitions

Anesthesia Time Unit: A time unit equals one 15-minute segment of time during which an anesthetic is administered. Anesthesia time starts when the anesthesiologist begins to prepare the patient for care in the operating room or in an equivalent area (the anesthesia in the equivalent area must be continuous with the anesthesia in the operating room). Partial 15-minute increments of 7.49 minutes or less are rounded down. Partial 15-minute increments of 7.50 minutes or more are rounded up. If less than 7.50 total minutes of a unit of time is billed, it will be reimbursed as one billable time unit.

Discontinuous Anesthesia Time: When counting anesthesia time, the anesthesiologist can add blocks of anesthesia time around an interruption in anesthesia time as long as the anesthesiologist is furnishing continuous anesthesia care within the time periods around the interruption. The medical record should be documented so that a medical record auditor can see the continuous and discontinuous periods that the reported total anesthesia time sums to the segments of continuous time when the anesthesiologist was present. For example: 1) The anesthesiologist has begun preparing the patient for induction, but the surgeon is temporarily unavailable, and the anesthesiologist leaves the patient under the observation of the operating room nurse, and 2) an IV is started in the induction room and there may be a break before induction of anesthesia in the operating room. As long as there is continuous monitoring of the patient within the blocks of anesthesia time, those blocks may be aggregated.

Mass General Brigham Health Plan Reimburses

- Anesthesia services involving administration of anesthesia, with the use of the anesthesia five-digit CPT code (00100 to 01999)
- Tap Block only covered for pain management in the post-op period
- The following, separately, based on the appropriate medical or surgical fee schedule:
  CPT 93503 *Placement of a Swan-Ganz catheter for monitoring purposes*
  CPT 36620 *Insertion of an intra-arterial monitoring line during surgery*
  CPT 36556 *Insertion of a central venous pressure monitor during surgery*
- Certified Registered Nurse Anesthetists (CRNA)

Mass General Brigham Health Plan Does *Not* Reimburse

- Anesthesia by surgeon: Modifier 47
- Anesthesia stand-by services
- Anesthesia qualifiers: CPT codes 99100-99140
- Anesthesia physical status modifiers: P1-P6
- Catheter insertion on the same day as epidural anesthesia delivery for surgery
- CPT codes designated by the ASA as “anesthesia care not normally required” or “not a primary procedure code”
- CRNA services performed by salaried facility employees
- Evaluation and management services for post-operative pain control on the day of surgery
- Evaluation and management services as part of the routine pre- and post-operative anesthetic service
- Local anesthesia which is considered part of the surgical procedure

- Inpatient pain management on the same day as epidural catheter insertion *or* a single epidural insertion
- Moderate (conscious) sedation (CPT codes 99151-99157) when billed with a procedure that includes conscious sedation
- Pain management outside post-operative pain control
- Post-operative pain management on the day of surgery (See section: Post-Operative Care (Inpatient) below)

CPT/HCPCS Codes

Note: This list of codes may not be all-inclusive

Obstetrical Anesthesia

Code	Descriptor	Comments
01960	Anesthesia for vaginal delivery only	Denied when submitted with CPT 01967
01961	Anesthesia for cesarean delivery only	Denied when submitted with CPT 01967-01968
01967	Neuraxial labor analgesia/anesthesia for planned vaginal delivery	Time unit cap applies: Base + Time for a total maximum cap of 20 units (300 minutes)
01968	Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia	Submit in addition to CPT 01967 when a planned vaginal delivery turns into a cesarean; not reimbursable when billed alone. This code in addition to 01967 is subject to a time unit cap: Base + Time for a total combined maximum cap of 24 units (360 minutes)
01969	Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia	Submit in addition to CPT 01967

Post-Operative Care (Inpatient)

Code	Descriptor	Comments
01996	Daily hospital management of epidural or subarachnoid continuous drug administration	Separately payable on days *subsequent* to surgery, but inappropriate on the day of surgery when the catheter was used for delivery of the surgical anesthetic. Submit only one unit, per post-operative day, regardless of the number of visits required to manage the member. Reimbursement is one flat fee.
62320 - 62321	Injection(s), of diagnostic or therapeutic substance(s) (e.g. anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, cervical or thoracic; without imaging guidance, or with imaging guidance (i.e. fluoroscopy or CT)	Submit for post-operative pain management on the day of surgery when NOT used as the surgical anesthetic technique. Report with modifier 59 and one unit of service.
62322-62323	Injection(s), of diagnostic or therapeutic substance(s) (e.g. anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); without imaging guidance or with imaging guidance (i.e. fluoroscopy or CT)	Submit for catheter insertion for post-operative pain management on the day of surgery when NOT used as the surgical anesthetic technique. Report with modifier 59 and one unit of service.
64416, 64446, 64448, 64449	Continuous block codes	When reported on the day of surgery, NO additional reporting of daily pain management is allowed.
99231-99233	Subsequent hospital care	Submit for inpatient post-operative pain management services, not described above. One unit per day.

Modifiers

Append the following anesthesia service specific modifiers to anesthesia service codes 00100 – 01999, and E/M codes submitted by anesthesiologists, as appropriate.

Modifier	Descriptor	Reimbursement
AA	Anesthesia services performed personally by physician	100% of anesthesia allowable
AD	Medical supervision by a physician for more than 4 concurrent procedures	3 base units
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals	50% of anesthesia allowable
QX	CRNA service with medical direction by a physician	50% of anesthesia allowable
QY	Medical direction of one CRNA by an anesthesiologist	50% of anesthesia allowable
QZ	CRNA service; without medical direction by a physician	No impact on reimbursement
47	Anesthesia performed by surgeon	No additional reimbursement for anesthesia by a surgeon, assistant surgeon, nursing staff, or any other non-anesthesiologist professional during a procedure

Provider Payment Guidelines and Documentation

- Report anesthesia services involving administration of anesthesia by the use of the anesthesia five-digit CPT code (00100-01999).
- When performing multiple surgical procedures during a single anesthetic administration, report only the anesthesia code (00100 series) with the highest base unit value. The time reported is the combined total minutes for all procedures.
- Bill discontinuous blocks of anesthesia time only if the patient is continuously monitored within the discontinuous blocks of time and documentation of monitoring in the medical record supports the time billed.
- An anesthesia time unit equals on 15-minute segment of time during which an anesthetic is administered. Partial 15-minute increments are: rounded down for 7.49 minutes or less or rounded up for 7.50 minutes or more. If less than 7.50 *total* minutes of a unit are billed, it is reimbursable as one billable time unit.

- Submit time in total minutes from the beginning to the end of clock time for the anesthesia service. Do NOT submit time units or add the base value to the total minutes billed. This will cause overpayment resulting in a post audit recovery.
- For **Commercial** and **Medicaid** claims, obstetrical anesthesia reimbursement for neuraxial/epidural labor is based on the base units + time units capped at the following units/minutes:
    - Vaginal delivery code 01967 – capped at a maximum of 20 units (300 minutes). The maximum units include base time.
    - Cesarean section delivery code 01968 – capped at a maximum of 24 units (360 minutes). This is combined with code 01967 for a total maximum cap. The maximum units include base time.
- For **Medicare Advantage** claims, see CMS Medicare Claims Processing Manual
- Submit electronic claims using the designated minute field; use three digits to record minutes (e.g. 22 minutes would be correctly submitted as 022, 124 minutes as 124).

Related Mass General Brigham Health Plan Payment Guidelines

Evaluation and Management Services
Acupuncture Services

References

American Society of Anesthesiology Crosswalk: A Guide for Surgery/Anesthesia CPT Codes
CMS Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners, Section 50 Payment for Anesthesiology Services
Federal Register November 2, 1999, pg. 59409
National Correct Coding Intitiative Policy Manual for Medicare Services, Chapter II, Anesthesia Services, CPT Codes 00000 - 01999

Publication History

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This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider's agreement, the terms and conditions of the provider's agreement shall prevail. Payment policies are intended to assist providers in obtaining Mass General Brigham Health Plan's payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy formulation takes into consideration a variety of factors including: the terms of the participating providers 'contract(s); scope of benefits included in a given member's benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.

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