Reimbursement Policy

Subject: **Professional Anesthesia Services**	
Policy Number: **G-07018**	Policy Section: **Anesthesia**
Last Approval Date: **06/13/2023**	Effective Date: **11/06/2020**

**** Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **https://provider.simplyhealthcareplans.com** or **https://provider.clearhealthalliance.com**. ****

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if Simply Healthcare Plans, Inc. (Simply) and Clear Health Alliance (CHA) covered the service for the member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology® (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Simply and CHA may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. Simply and CHA strives to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

FLSMPLY-CD-RP-045452-23-CPN44635 January 2024

Policy

Simply and CHA allow reimbursement of anesthesia services rendered by professional providers for covered members unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

Reimbursement is based upon:

- The reimbursement formula for the allowance and time increments in accordance with state guidelines.
- Proper use of applicable modifiers.

Providers must report anesthesia services in minutes. Anesthesia claims submitted with an indicator other than minutes may be rejected or denied. Start and stop times must be documented in the member's medical record. Anesthesia time starts with the preparation of the member for administration of anesthesia and stops when the anesthesia provider is no longer in personal and continuous attendance.

Simply and CHA allow any portion of a 15-minute increment to equal one unit. Simply and CHA use the following reimbursement formula for allowance calculation: anesthesia base rate plus (time divided by 15 multiplied by the conversion factor).

Anesthesia modifiers

Anesthesia modifiers are appended to the applicable procedure code to indicate the specific anesthesia service or who performed the service. Modifiers identifying who performed the anesthesia service must be billed in the primary modifier field to receive appropriate reimbursement. Additional or reduced payment for modifiers is based on state requirements, as applicable. Claims submitted for anesthesiology services without the appropriate modifier will be denied. Please review the attachment below for reimbursement information for specific anesthesia modifiers.

Simply and CHA require modifiers QK, QS, and 78 to be billed as appropriate for anesthesia services.

- Modifier QK: medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals — reimbursement is based on 50% of the applicable fee schedule or contracted/negotiated amount.
- Modifier QS: monitored anesthesiology care services (can be billed by a qualified nonphysician anesthetist or a physician).
- Modifier 78: unplanned return to the operating/procedure room by the same physician or other qualified healthcare professional following initial procedure for a related procedure during the postoperative period.

Simply and CHA allow reimbursement to medically directed certified registered nurse anesthetist (CRNA's) based on 80%, and to the physician billing Modifier QK based on 20% of the applicable fee schedule or contracted/negotiated rate.

Multiple anesthesia procedures
Simply and CHA allow reimbursement for professional anesthesia services during multiple procedures. Reimbursement is based on the anesthesia procedure with the highest base unit value and the overall time of all anesthesia procedures.

Obstetrical anesthesia
Simply and CHA allow reimbursement for professional neuraxial epidural anesthesia services provided in conjunction with labor and delivery for up to 360 minutes by either the delivering physician or a qualified provider other than the delivering physician based on the time the provider is physically present with the member. Providers must submit additional documentation upon dispute for consideration of reimbursement of time in excess of 360 minutes. Reimbursement is based on one of the following:

- For the delivering physician—based on a flat rate or fee schedule using the surgical CPT pain management codes for epidural analgesia.
- For a qualified provider other than the delivering physician—based on:
  - The allowance calculation.
  - The inclusion of catheter insertion and anesthesia administration.

Services provided in conjunction with anesthesia
Simply and CHA allow separate reimbursement for the following services provided in conjunction with the anesthesia procedure or as a separate service:

- Swan-Ganz catheter insertion.
- Central venous pressure line insertion.
- Intra-arterial lines.
- Emergency intubation (must be provided in conjunction with the anesthesia procedure to be considered for reimbursement).
- Critical care visits.
- Transesophageal echocardiography.

Note: Reimbursement is based on the applicable fee schedule or contracted/negotiated rate with no reporting of time.

Nonreimbursable
Simply and CHA does not reimburse for:

- Use of patient status modifiers or qualifying circumstances codes denoting additional complexity levels.
- Anesthesia consultations on the same date as surgery or the day prior to surgery if part of the preoperative assessment.
- Anesthesia services performed for noncovered procedures, including services considered not medically necessary, experimental, and/or investigational.
- Anesthesia services by the provider performing the basic procedure, except for a delivering physician providing continuous epidural analgesia.
- Local anesthesia considered incidental to the surgical procedure.
- Standby anesthesia services.

Related Coding	
Code	**Description**
Anesthesia Modifiers	**Anesthesia Modifiers**

Policy History	
06/13/2023	Review approved: updated policy template, updated exemption to require modifiers QK, QS, and 78 to be billed as appropriate for anesthesia services
11/06/2020	Review approved and effective: minor administrative updates to policy body
10/03/2018	Review approved: policy template updated
12/01/2018	Policy template updated
01/03/2017	Review approved: policy language updated
02/27/2012	Review approved 02/27/2012 and effective 10/01/2012: updated start and stop time language due to change in *HIPAA 5010* instructions
07/18/2011	Review approved 07/18/2011 and effective 11/05/2009: background section/policy template updated; start/stop time language added
07/08/2009	Review approved 07/08/2009 and effective 11/05/2009: policy combined with Anesthesia Modifiers #06-165; reimbursement formula for anesthesia calculation clarified; anesthesia modifier information added; non reimbursement of patient status modifiers clarified; medical criteria removed; dental anesthesia benefit information removed; Florida unit rounding clarified; obstetrical epidural anesthesia limit added; Background section/policy template updated; references to Modifier Usage #06-066 and Modifier 23 Unusual Anesthesia #07-021 policies added
05/30/2007	Initial approval 05/30/2007 and effective 07/01/2007

References and Research Materials

This policy has been developed through consideration of the following:

- American Society of Anesthesiologists
- CMS
- Optum EncoderPro 2023
- State contract
- State Medicaid

Definitions	
Anesthesia	Refers to the drugs or substances that cause a loss of consciousness or sensitivity to pain
Base unit	The relative value unit associated with each anesthesia procedure code as assigned by CMS

Time unit	An increment of 15 minutes where each 15-minute increment constitutes one time unit
Conversion factor	A geographic-specific amount that varies by the locality where the anesthesia is administered
General Reimbursement Policy Definitions	
Related Policies and Materials	
Maternity Services	
Modifier Usage	
Reduced and Discontinued Services	
Scope of Practice	