ASPIRUS HEALTH PLAN

PAYMENT POLICY

Anesthesia

Policy Number: ASP21001A1

Effective Date: January 1, 2021
Last Update: April 19, 2024

Payment Policy History

DATE	SUMMARY OF CHANGE
April 19, 2024	Annual review completed. Intent of policy unchanged; updates were made to clarify wording and to clean up grammar and stylization.
June 22, 2023	Annual policy review completed. Updates made to definitions, provider eligibility, and Modifiers/CPT/HCPCs/Revenue Codes sections.
December 30, 2021	Annual review of the payment policy was completed. The NGS source information was updated and grammatical and punctuation corrections were made to the policy.
January 1, 2021	The Anesthesia policy was published by Aspirus Health Plan.

Applicable Product(s)

This policy applies to:

- Aspirus Essential Rx
- Aspirus Elite Rx
- Aspirus Elite

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Payment Policy Instructions

A payment policy assists in determining provider reimbursement for specific covered services. To receive payment, the provider must be in a contractual relationship with Aspirus Health Plan and provide services to a member enrolled in one of Aspirus Health Plan products. This payment policy is intended to provide a foundation for system configuration, work instructions, call scripts, and provider communications. A payment policy describes the rules for payment, which include applicable fee schedules, additional payment rules by regulatory bodies, and contractual terms. This policy is a general guideline and may be superseded by specific provider contract language.

Payment Policy Overview

This policy outlines the appropriate use of modifiers, and the billing and payment guidelines associated with general anesthesia and monitored anesthesia care (MAC).

Policy Definitions

TERM	NARRATIVE DESCRIPTION
Anesthesiologist Assistant (AA)	An AA is a maters level educated individual who can work collaboratively under the direction of an anesthesiologist. Anesthesiologist assistants obtain pre-anesthetic health history, perform preoperative physical exams, establish non-invasive and invasive monitors, administer medications, evaluate, and treat life-threatening situations, and execute general and regional anesthetic techniques, as delegated by the anesthesiologist.
Base Units or Base Value	Means the number of units assigned to the ASA code (00100 – 01990, 01999).
Certified Registered Nurse Anesthetist (CRNA)	An advanced practice registered nurse (APRN) who has acquired graduate-level education and board certification in anesthesia.
Concurrency	The maximum number of procedures that the physician is medically directing within the context of a single procedure and whether these other procedures overlap each other.
General Anesthesia	Loss of ability to perceive pain, associated with the loss of consciousness, produced by intravenous infusion of drugs or inhalation of anesthetic agents.
Medically Directed	Medical direction occurs if the physician medically directs qualified individuals in two, three, or four concurrent cases, and the physician performs the following activities: • Pre-anesthetic examination and evaluation; • Prescribes the anesthesia plan; • Personally participates in the most demanding procedures in the anesthesia plan, including, if applicable, induction and emergence; • Ensures that any procedures in the • anesthesia plan that he or she does not

	perform are performed by a qualified anesthetist; • Monitors the course of anesthesia administration at frequent intervals; • Remains physically present and available for immediate diagnosis and treatment of emergencies; and • Provides indicated post-anesthesia care. The medical record must reflect that the physician performed services as indicated above. It should be noted that if anesthesiologists are in a group practice, one physician may provide the pre-and/ post anesthesia exam and evaluation while another fulfills the other criteria. The medical record must reflect that services were performed by multiple physicians and identify the physicians who furnished them
Medically Supervised	Based on review of Medicare documents medically supervised care occurs when the anesthesiologist engages in supervising more than four procedures concurrently or is performing other services for a significant period while directing concurrent procedures.
Monitored Anesthesia Care (MAC)	Intra-operative monitoring by an anesthesiologist or other qualified provider under the direction of the anesthesiologist, of the patient's vital physiological signs in anticipation of the need for admission of general anesthesia or the development of adverse physiological patient reaction to the surgical procedure. MAC is eligible for coverage when performed by an eligible provider (see above), and all the following criteria is met: • MAC is requested by the attending physician or operating surgeon;

	• There is performance of a pre-anesthetic examination and evaluation; • There is a prescriptive anesthesia plan outlining the anesthesia care required; • Administration of necessary oral and parenteral medication takes place, and; • There is continuous physical presence of the anesthesiologist or in the case of medical direction, a qualified anesthetist
Personally Performed	Means that the physician personally performed all the pre-operative, intra-operative, and postoperative anesthesia care. Medicare guidelines states the anesthesiologist may bill for personally performed services when he or she: • Personally performed the entire anesthesia service alone. Are Involved with one anesthesia case with a resident, the physician is a teaching physician. • Participate in the training of physician residents in a single anesthesia case, two concurrent anesthesia cases involving residents or a single anesthesia case involving a resident that is concurrent to another case paid under the medical direction rules. • Participate in the training of physician residents in a single anesthesia care, two concurrent anesthesia cases involving residents or a single anesthesia case involving a resident that is concurrent to another case paid under the medical direction rules. The physician meets the teaching criteria in Section 100.14 and the service is furnished on or after January 1, 2010

	• Are continuously involved in a single case involving a student nurse anesthetist.

Enrollee Eligibility Criteria

This section of the policy provides information that is specific to the Aspirus Health Plan member, including information about the criteria the member must meet in order for the service(s) in the policy to be eligible for payment.

The member must be actively enrolled in an Aspirus Health Plan Medicare Advantage plan.

Eligible Providers or Facilities

Outlined below are the specific criteria a provider must meet in order for the service(s) in this policy to be eligible for payment.

Provider

The following providers are eligible to furnish and bill for the Anesthesia services:

- Physician Anesthesiologist
- Certified Registered Nurse Assistant (CRNA)
- Anesthesiologist Assistant (AA)

Facility

Not applicable.

Other and/or Additional Information

Not applicable.

Excluded Provider Types

Outlined below is information regarding providers who are not eligible to furnish the service(s) listed in this policy.

Not applicable.

Modifiers, CPT, HCPCS and Revenue Codes

General Information

The Current Procedural Terminology (CPT®), Healthcare Common Procedure Code System (HCPCS), and Revenue codes listed in this policy are for reference purposes only. Including information in this policy does not imply that the service described by a code is a covered or non-covered health service. The inclusion of a code does not imply any right to reimbursement or guarantee of claim payment.

Anesthesia Modifiers

Modifiers appended to anesthesia claim lines have a significant impact on payment. Detailed information regarding anesthesia modifiers, their use and impact on payment is outlined in the "Payment Information" section of this policy.

CPT and/or HCPCS Code(s)

For general anesthesia and monitored anesthesia care (MAC) the code-set established by the American Society of Anesthesiologists (ASA) is used to bill for anesthesia care. Services should be billed using the most current and appropriate ASA code.

CPT® is a registered trademark of the American Medical Association.

Revenue Codes

Not applicable.

Payment Information

General Anesthesia

Code-Set

Aspirus Health Plan uses anesthesia codes and base values adopted from the list values established by the American Society of Anesthesiologists (ASA).

Payment Guidelines

Anesthesia administration includes the following services:

- Preoperative and postoperative visits
- Anesthesia care during the procedure
- Administration of fluids and blood
- Usual monitoring (e.g., ECG, temperature, blood pressure, oximetry, capnography, mass spectrometry) as defined by ASA and/or CPT guidelines.

General Anesthesia is personally performed by an anesthesiologist or CRNA/AA (medically directed by an anesthesiologist, or medically supervised by an anesthesiologist).

Outlined below is general information related to the reimbursement formulas used for all Aspirus Health Plan Medicare Advantage products.

Reimbursement Formula

REIMBURSEMENT FORMULA	PAYMENT INFORMATION
Personally Performed and Medically Directed Formula (ASA Base Units) + (Total Time / 15 (rounded to the nearest tenth)) x Current Conversion Factor)	***Personally Performed*** – 100% of the allowed amount ***Medically Directed*** – 50% of the allowed amount

Medically Supervised Allow three (3) base units, and one (1) additional base unit when it is demonstrated that the physician was present at the induction x Current Conversion Factor	Refer to the modifier payment grid listed below.

Monitored Anesthesia Care

General Information

Monitored anesthesia care involves the intra-operative monitoring by a physician or qualified individual under the medical direction of a physician or 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. It 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.

Modifier Payment Grid and Additional Payment Information

The allowed amount is determined based on the anesthesia procedure that has the highest base unit value. The formula for payments:

MODIFIER(S)	NARRATIVE DESCRIPTION	Oversight	Provider Type	Additional Medicare Info
AD	Medical Supervision by a physician; more than 4 concurrent anesthesia procedures	Medically Directed / Supervised	Anesthesiologist	Allow three (3) base units, and one (1) additional time unit when it is demonstrated that the physician was present at the induction
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals	Medically Directed / Supervised	Anesthesiologist	Reimbursed at 50% of the Medicare allowed amount
QX	CRNA service with medical direction by a physician	Medically Directed / Supervised	CRNA / AA	Reimbursed at 50% of the Medicare allowed amount
QY	Medical direction of one qualified non-physician anesthetist by an anesthesiologist	Medically Directed / Supervised	Anesthesiologist	Reimbursed at 50% of the Medicare allowed amount
G8	Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedures	Monitored Anesthesia Care (MAC)	Anesthesiologist CRNA / AA	Informational modifier to indicate MAC services were provided The personally performed or the appropriate medical direction modifier must be submitted with this modifier. Submit actual time on the claim. Payment guidelines – same as general anesthesia
G9	Monitored anesthesia care for patient who has a history of severe cardio-pulmonary condition	Monitored Anesthesia Care (MAC)	Anesthesiologist, CRNA /AA	See G8
QS	Monitored anesthesia care service (The –QS modifier can be used by a physician or a qualified non-physician anesthetist)	Monitored Anesthesia Care (MAC)	Anesthesiologist, CRNA /AA	See G8
AA	Anesthesia Services performed personally by the anesthesiologist	Personally Performed	Anesthesiologist	Reimbursed at 100% of the Medicare allowed amount
QZ	CRNA service without medical direction by a physician	Personally Performed	CRNA / AA	Reimbursed at 100% of the Medicare allowed amount
GC	These services have been performed by a resident under the direction of a teaching physician.	Resident - Teaching Facility	Anesthesiologist	The GC modifier is reported by the teaching physician to indicate they rendered the service in compliance with Chapter 12, Section 100.1.2 of Medicare's Claims Processing Manual. If the teaching anesthesiologist is involved in a single case with an anesthesiology resident payment is the same as if the physician performed the service alone. If the teaching anesthesiologist is medically directing 2 – 4 concurrent cases, any of which involved residents, payment is based on 50% of the anesthesia fee schedule (standard for payment method).

Physical Status Modifiers (Informational)

Modifier	Modifier Narrative
P1	A normal healthy patient
P2	A patient with mild systemic disease
P3	A patient with severe systemic disease
P4	A patient with severe systemic disease that is a constant threat to life
P5	A moribund patient who is not expected to survive without the operation
P6	A declared brain-dead patient whose organs are being removed for donor purposes

Billing Requirements and Directions

When submitting claims follow the guidelines outlined below:

- Claims should be submitted using the 837-P format or the electronic equivalent.
- Do not submit anesthesia base units on the claim. They will be included in the calculation of the allowed amount.
- For anesthesia time:
  - Submit the exact number of minutes from the preparation of the patient for induction to the time the anesthesiologist or CRNA are no longer in personal attendance or continue to be required.
  - Aspirus Health Plan will translate the number of anesthesia minutes submitted by the provider to units of service.
  - Fifteen (15) minutes of time equals one unit of service; and
  - Units will be calculated to one decimal point. (Example: 62 minutes / 15 = 4.1 units of service).

Prior Authorization, Notification and Threshold Information

Prior Authorization and Notification Requirements

Aspirus Health Plan does update authorization, notification, and threshold requirements from time-to- time. The most current prior authorization requirements can be found here.

Threshold Information

Related Payment Policy Information

Outlined below are other policies that may relate to this policy and/or may have an impact on this policy.

POLICY NUMBER	POLICY TITLE

Aspirus Health Plan payment policies are updated from time to time. The most current Aspirus Health Plan payment policies can be found here.

Source Documents and Regulatory References

Listed below are links to CMS, MHCP, and statutory and regulatory references used to create this policy.

NGS

NGS, Anesthesia Services, General Anesthesia Information

CMS

Anesthesiologist Center

IOM-04 Medicare Claims Processing Manual, Chapter 12 Physicians/Non-Physician Practitioners, Section 50 and Section 100.1.2

Disclaimer

"Payment Policies assist in administering payment for Aspirus Health Plan benefits under Aspirus Health Plan benefit Plans. Payment Policies are intended to serve only as a general reference resource regarding Aspirus Health Plan administration of health benefits and are not intended to address all issues related to payment for health care services provided to Aspirus Health Plan members. When submitting claims, all providers must first identify member eligibility, federal and state legislation or regulatory guidance regarding claims submission, Aspirus Health Plan provider participation agreement contract terms, and the member-specific Evidence of Coverage (EOC) or other benefit document. In the event of a conflict, these sources supersede the Payment Policies. Payment Policies are provided for informational purposes and do not constitute coding or compliance advice. Providers are responsible for submission of accurate and compliant claims. In addition to Payment Policies, Aspirus Health Plan also uses tools developed by third parties, such as the Current Procedural Terminology (CPT®), InterQual guidelines, Centers for Medicare and Medicaid Services (CMS), the Minnesota Department of Human Services (DHS), or other coding guidelines, to assist in administering health benefits. References to CPT® or other sources in Aspirus Health Plan Payment Policies are for definitional purposes only and do not imply any right to payment. Other Aspirus Health Plan Policies and Coverage Determination Guidelines may also apply. Aspirus Health Plan reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary and to administer payments in a manner other thanas described by Aspirus Health Plan Payment Policies when necessitated by operational considerations."