Anesthesia Professional Payment Policy

Applies to the following Tufts Health Plan products:

- ☒ Tufts Health Plan Commercial[1]
- ☒ Tufts Medicare Preferred HMO (a Medicare Advantage product)[2]
- ☒ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)[2]

The following payment policy applies to Tufts Health Plan contracting anesthesiologists rendering anesthesia services in a physician's office, inpatient or outpatient facility.

In addition to the specific information contained in this policy, providers must adhere to the information outlined in the Professional Services and Facilities Payment Policy.

During the rapidly evolving situation around COVID-19, Tufts Health Plan's payment policy for medically necessary anesthesia services is documented in the Coronavirus (COVID-19) Updates for Providers page.

Note: Audit and disclaimer information is located at the end of this document.

POLICY

Tufts Health Plan covers the administration of anesthesia for medically necessary services, in accordance with the member's benefits.

GENERAL BENEFIT INFORMATION

Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider portal or by contacting Commercial Provider Services or Senior Products Provider Relations.

Note: There is no member responsibility for covered services for Tufts Health Plan SCO members.

REFERRAL/PRIOR AUTHORIZATION/NOTIFICATION REQUIREMENTS

Certain procedures, items and/or services may require referral and/or prior authorization. While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you must confirm that prior authorization has been obtained. For more information, refer to the Referral, Authorization and Notification Policy.

Anesthesiologists are not required to obtain referrals for anesthesia services performed in conjunction with a surgical procedure; however, referrals are required for pain management and non-anesthesia services, such as an evaluation and management (E&M) service.

Note: All inpatient admissions require inpatient notification prior to services being rendered. Professional claims will be denied if the notification to the hospital has not been obtained by the facility. It is the responsibility of the admitting practitioner and/or facility to obtain a referral and/or inpatient notification, as necessary.

Outpatient Interventional Pain Management

Providers must request prior authorization for interventional pain management services through National Imaging Associates (NIA). Providers can contact NIA for prior authorization through RadMD.

Note: Prior authorization is not required for interventional pain management spine services rendered in an emergency department, observation, or hospital inpatient setting. Refer to the Spinal Conditions Management Prior Authorization Program for more information.

For a list of CPT codes subject to prior authorization, refer to the Spinal Conditions Management Program Code Matrix.

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[1] Commercial products include HMO, POS, PPO, and CareLink℠ when Tufts Health Plan is the primary administrator.

[2] Tufts Medicare Preferred and Tufts Health Plan SCO are collectively referred to in this payment policy as Senior Products.

BILLING INSTRUCTIONS

Unless otherwise stated, Tufts Health Plan follows industry standard coding guidelines. Refer to current industry standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules. For more information, refer to the Professional Services and Facilities Payment Policy.

- Report the start and end time for administration of anesthesia. Measurement of time begins when the anesthesiologist starts to prepare the patient for anesthesia care in the operating room (or equivalent area) and ends when the anesthesiologist is no longer in personal attendance. Time that the anesthesiologist is not in personal attendance is considered nonbillable time.
- Submit the total number of minutes to indicate anesthesia services rendered (e.g., submit two hours and ten minutes as 130 minutes). Except for CPT codes 01953 and 01996, claims submitted in units will be rejected.
- If submitting multiple anesthesia services on the same day, submit the primary anesthesia service only with the highest base unit value (BUV). Total time should be submitted for all procedures performed.

Claims Processing for Anesthesia Services

During claims processing, submitted minutes are converted into time units.

Commercial products: Each 15-minute interval is converted to one time unit, rounding up to the next unit for 8-14 minutes and rounding down for 1-7 minutes.

Senior Products: Each 15-minute interval is converted to one time unit, rounding to the nearest tenth of a unit (one decimal place).

Note: Do not submit BUVs. Tufts Health Plan's compensation calculation includes BUVs.

If submitting a paper claim, the chart time must be reported to validate the number of minutes billed. The chart time must also be reported in the patient's record.

Certified Registered Nurse Anesthetist (CRNA) Services

Tufts Health Plan credentials CRNAs in accordance with applicable state regulations. Tufts Health Plan compensates medically necessary CRNA services when care is provided either independently (in applicable states) or under the supervision of a participating anesthesiologist and billed under the supervising anesthesiologist's provider identification number.

When billing for practitioner-directed/supervised CRNA services, anesthesia claims should be submitted with the appropriate procedure code, modifier, and applicable time units for both the physician and the CRNA on **separate** claim lines. The appropriate anesthesia modifier must be submitted to indicate whether the service was personally performed by an anesthesiologist or in conjunction with a CRNA.

Note: CRNAs in Massachusetts[3] and New Hampshire who contract with Tufts Health Plan may bill directly for services.

Anesthesia Modifiers

As defined in the AMA CPT Manual, "all anesthesia services are reported by use of the anesthesia five-digit procedure code (00100-01999) plus the addition of a physical status modifier. The use of other optional modifiers may be appropriate."

Common Anesthesia Modifiers

Modifier	Compensation Impact
AA	100% of Tufts Health Plan fee schedule/allowed amount
AD	50% of Tufts Health Plan fee schedule/allowed amount
G8[4]	No compensation. Used for reporting purposes only
G9[3]	No compensation. Used for reporting purposes only

[3] In accordance with M.G.L. Chapter 260.
[4] Should be billed with the appropriate modifier to denote whether the service was performed by an anesthesiologist or in conjunction with a CRNA.

Modifier	Compensation Impact
QK	50% of Tufts Health Plan fee schedule/allowed amount
QS[3]	No compensation. Used for reporting purposes only
QX	50% of Tufts Health Plan fee schedule/allowed amount
QY	50% of Tufts Health Plan fee schedule/allowed amount
QZ	No compensation[5]

Physical status modifiers: P1, P2, P3, P4, P5, P6

E&M Services

Submitting a separate E&M service in place of an attending or consulting practitioner is appropriate if the only service provided was a preoperative evaluation and no anesthesia was administered.

Submitting an E&M procedure code for a preoperative consultation is not appropriate unless the surgery is cancelled subsequent to the preoperative visit. In this case, compensation will be considered for an E&M service.

Explanation of Payment: The explanation of payment (EOP) will reflect time units for anesthesia services rendered.

COMPENSATION/REIMBURSEMENT INFORMATION

Providers are compensated according to the applicable contracted rates and applicable fee schedules, regardless of the address where the service is rendered. For more information, refer to the Professional Services and Facilities Payment Policy.

Compensation for anesthesia services is based on standard CMS and American Society of Anesthesiology method pricing: **(time units + BUV) x anesthesia conversion factor**. BUVs will automatically be included in the compensation. Pre- and postoperative consultations are considered part of the BUV.

Tufts Health Plan compensates the primary procedure in conjunction with the time units reported and BUVs associated with that procedure.

The following table identifies the source of each component that is utilized in anesthesia method pricing:

Component	Source of Information
Total number of minutes	Submitted on the claim by the provider
Time units	Submitted on the claim by the provider
Base unit value (BUV)	Obtained from American Society of Anesthesiology (ASA) Guide
Conversion factor	Tufts Health Plan compensation rate

All Products

Colorectal Cancer Screening

Tufts Health Plan does not routinely compensate 00811 (anesthesia for lower intestinal endoscopic procedures) if billed with modifier PT unless a CPT surgery code (10000-69999) has been billed for the same date of service by any provider.

Conscious Sedation

Conscious sedation is not considered for separate compensation if billed in conjunction with a surgical procedure code, as it is included in the compensation for the surgical procedure.

CRNA Services

When a CRNA performs anesthesia services under the medical direction and/or supervision of an anesthesiologist, both the anesthesiologist/physician and the CRNA will be compensated at 50 percent of the allowed amount for that service. Compensation will be assigned to the practitioner listed on the claim.

Tufts Health Plan does not routinely compensate anesthesia services (00100-01999) billed by a CRNA without the appropriate CRNA modifier (QX or QZ).

[5] Applies to Massachusetts and Rhode Island CRNAs only. Contracting CRNAs in New Hampshire who bill directly for services will receive 100% of the allowable amount, in accordance with state regulations.

E&M and Anesthesia Services
E&M services are not separately compensated when billed with anesthesia services, as they are included in the payment for the anesthesia services. However, Tufts Health Plan will consider separate compensation if the appropriate modifier is appended.

Similarly, E&M services billed with anesthesia services on the same date of service or the day prior to surgery are not separately compensated. Refer to the AMA CPT Manual and the NCCI Policy Manual for more information.

Maximum Units
Tufts Health Plan does not routinely compensate for anesthesia codes that have exceeded our daily maximum unit allowed.

Modifiers for Anesthesia Services
Tufts Health Plan does not routinely compensate any code when billed with multiple anesthesia modifiers on the same claim line.

Pain Management Injections
Tufts Health Plan does not routinely compensate anesthesia and moderate sedation services (00300, 00400, 00600, 01937-01942, 01991-01992, 99152-99153, 99156-99157) if billed with pain management services but billed without a surgical code (10021-69990) by any provider for a member aged 18 or older on the date of service.

Tufts Health Plan does not routinely compensate for daily hospital management of epidural or subarachnoid continuous drug administration (01996) when billed more than three days following a general anesthesia service.

Qualifying Circumstances
Tufts Health Plan does not routinely compensate the following CPT procedure codes:

- 99116 (anesthesia complicated by utilization of total body hypothermia)
- 99135 (anesthesia complicated by utilization of controlled hypotension)
- 99100 (anesthesia for patient of extreme age, under one year or over seventy)
- 99140 (anesthesia complicated by emergency conditions)

Commercial products only
Anesthesia Assistance with Elective Gastrointestinal Endoscopic Procedures
Tufts Health Plan may cover anesthesia assistance for gastrointestinal endoscopic procedures if there is documentation in the member's medical record that certain risk factors and/or a significant medical condition exists. Refer to the Anesthesia Assistance with Elective Gastrointestinal Endoscopic Procedures Medical Necessity Guideline for more information.

Anesthesia Surgical Exceptions
Anesthesiologists are eligible for compensation for certain surgical CPT procedure codes at the network contracted rate. Refer to the Anesthesia Surgical Procedure Code List for a list of these surgical CPT procedure codes.

Fluoroscopic Procedure Interpretation
Anesthesiologists are eligible for compensation for certain fluoroscopic procedure interpretation codes. For information regarding procedure codes that anesthesiologists are privileged to perform, refer to the Imaging Privileging Program chapter of the Commercial Provider Manual.

When submitted appropriately, anesthesiologists are compensated globally (technical and professional component of these fluoroscopic procedures).

Medical Supervision/Direction of Anesthesia Services
Tufts Health Plan does not routinely compensate any anesthesiologist's claim without medical supervision/direction modifiers if a CRNA claim with medical direction has previously been billed.

Obstetrical Services
Tufts Health Plan compensates for professional services for CPT code 01967 (analgesia/anesthesia for planned vaginal delivery) at 13 time units (195 minutes), regardless of the number of time units billed. CPT codes 01967 and 01968 (anesthesia for Cesarean delivery following neuraxial labor analgesia/ anesthesia care) **are** compensated separately.

Senior Products only

Epidural Steroid Injections

Tufts Health Plan does not routinely compensate epidural steroid injection (62320, 62321, 62322, 62323, 64479-64484, 0228T, 0229T, 0230T, 0231T) if axial spinal pain (back pain) is the only diagnosis.

Professional Component of Radiology Services in Facilities

Tufts Health Plan does not routinely compensate professional radiology services billed by an anesthesiologist in the inpatient or outpatient hospital setting.

DOCUMENT HISTORY

- March 2022: Coding updates; replaced deleted codes 01935-01936 with codes 01937-01942, effective for dates of service on or after January 1, 2022
- March 2021: Updated billing requirements for CRNAs in Massachusetts, effective for dates of
- service on or after January 1, 2021
- January 2021: Added edit for maximum anesthesia units, effective for dates of service on or after April 1, 2021
- November 2019: Clarified existing time unit conversion method for Tufts Health Plan Senior Products claims
- October 2019: Policy reviewed by committee; added Tufts Health Plan Senior Products content to combine policies
- November 2018: Added claim edits for anesthesia for colorectal cancer screening; CRNA services; medical supervision and direction of anesthesia services, effective for dates of service on or after January 1, 2019
- June 2018: Template updates
- November 2017: Added edits for anesthesia for pain management injections and modifiers for anesthesia services effective for dates of service on or after January 1, 2018
- July 2017: Added edit for epidurals and postoperative pain management
- January 2017: Template updates; policy reviewed
- January 2016: Added billing and compensation information for NH CRNAs

AUDIT AND DISCLAIMER INFORMATION

Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, Tufts Health Plan will expect the provider/facility to refund all payments related to noncompliance. For more information about Tufts Health Plan's audit policies, refer to the Provider website.

This policy provides information on Tufts Health Plan claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication 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 requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the Tufts Health Plan products, as identified in the checkboxes on the first page, and to CareLink℠ for providers in Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna's provider agreements with respect to CareLink members. This policy does not apply to the Private Health Care Systems (PHCS) network (also known as Multiplan). Tufts Health Plan reserves the right to amend a payment policy at its discretion.