Anesthesia Professional Payment Policy

Applies to the following Tufts Health Plan products:

☒ Tufts Health Plan Commercial (including Tufts Health Freedom Plan)
☐ Tufts Medicare Preferred HMO (a Medicare Advantage product)
☐ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)

The following payment policy applies to Tufts Health Plan contracting anesthesiologists rendering anesthesia services in a physician’s office, inpatient or outpatient facility. For information on Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options, click here.

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.

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, as described below.

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 website or by contacting Commercial Provider Services.

AUTHORIZED REQUIREMENTS
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 and surgical day care services require inpatient notification prior to services being rendered. Professional claims will be denied if the notification to the hospital has not been obtained. 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.

BILLING INSTRUCTIONS
- 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., if the total time of anesthesia services is two hours and ten minutes, services should be submitted as 130 minutes).

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1 Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLinkSM when Tufts Health Plan is the primary administrator.
• 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 submitted in units will be rejected.
  – **Note:** Procedure codes 01953 and 01996 will be accepted when submitted in units and are subject to Tufts Health Plan's **Maximum Units** policy.

### Claims Processing for Anesthesia Services

During claims processing, submitted minutes are converted into time units. Each 15-minute interval is converted to 1 time unit, rounding up to the next unit for 8-14 minutes and rounding down for 1-7 minutes.

**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 does not currently credential CRNAs in Massachusetts or Rhode Island. Tufts Health Plan compensates medically necessary CRNA services when care is provided 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 New Hampshire who are contracted 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:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Compensation Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA</td>
<td>100% of Tufts Health Plan fee schedule/allowed amount</td>
</tr>
<tr>
<td>AD</td>
<td>50% of Tufts Health Plan fee schedule/allowed amount</td>
</tr>
<tr>
<td>G8²</td>
<td>No compensation. Used for reporting purposes only</td>
</tr>
<tr>
<td>G9²</td>
<td>No compensation. Used for reporting purposes only</td>
</tr>
<tr>
<td>QK</td>
<td>50% of Tufts Health Plan fee schedule/allowed amount</td>
</tr>
<tr>
<td>Q5²</td>
<td>No compensation. Used for reporting purposes only</td>
</tr>
<tr>
<td>QX</td>
<td>50% of Tufts Health Plan fee schedule/allowed amount</td>
</tr>
<tr>
<td>QY</td>
<td>50% of Tufts Health Plan fee schedule/allowed amount</td>
</tr>
<tr>
<td>QZ</td>
<td>No compensation</td>
</tr>
</tbody>
</table>

**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.

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² Should be billed with the appropriate modifier to denote whether the service was performed by an anesthesiologist or in conjunction with a CRNA.
Explanation of Payment: The explanation of payment (EOP) will reflect time units for anesthesia services rendered.

COMPENSATION/REIMBURSEMENT INFORMATION

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

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

<table>
<thead>
<tr>
<th>Component</th>
<th>Source of Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of minutes</td>
<td>Submitted on the claim by the provider</td>
</tr>
<tr>
<td>Time units</td>
<td>Submitted on the claim by the provider</td>
</tr>
<tr>
<td>Base unit value (BUV)</td>
<td>Obtained from American Society of Anesthesiology (ASA) Guide</td>
</tr>
<tr>
<td>Conversion factor</td>
<td>Tufts Health Plan compensation rate</td>
</tr>
</tbody>
</table>

Anesthesia Assistance with Elective Gastrointestinal Endoscopic Procedures

Tufts Health Plan may cover anesthesia assistance for gastrointestinal endoscopic procedures when there is documentation in the 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.

Colorectal Cancer Screening

Effective for dates of service on or after January 1, 2019, Tufts Health Plan will not routinely compensate 00811 (Anesthesia for lower intestinal endoscopic procedures) when billed with modifier PT and a CPT surgery code (10000-69999) has not been billed for the same date of service by any provider.

Anesthesia for 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. Procedure codes 01967 and 01968 (anesthesia for Cesarean delivery following neuraxial labor analgesia/anesthesia care) are compensated separately.

Anesthesia for Pain Management Injections

Effective for dates of service on or after January 1, 2018, Tufts Health Plan will not routinely compensate anesthesia and moderate sedation services (00300, 00400, 00600, 01935-01936, 01991-01992, 99152-99153, 99156-99157) when billed with pain management services and billed without a surgical code (10021-69990) by any provider for a patient age 18 or older.

Anesthesia Surgical Exceptions

Anesthesiologists are eligible for compensation for some 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.

Conscious Sedation

Conscious sedation is not considered for separate compensation when billed in conjunction with a surgical procedure code, as it is included in the compensation for the surgical procedure. For additional information, refer to Appendix G in the CPT manual.

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.

Effective for dates of service on or after January 1, 2019, Tufts Health Plan will not routinely compensate anesthesia services (00100-01999) billed by a CRNA without the appropriate CRNA modifier (QX or QZ).
Epidurals for Postoperative Pain Management
Tufts Health Plan will 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.

E&M and Anesthesia Services
Tufts Health Plan does not routinely compensate for the following:
- E&M services when billed with anesthesia services, as it is included in the anesthesia service; however, Tufts Health Plan will consider compensating the E&M service when an appropriate modifier is appended
- E&M services billed with anesthesia services on the same date of service or the day prior to surgery

Refer to the AMA CPT Manual and the NCCI Policy Manual for more information.

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 and Medical Direction of Anesthesia Services
Effective for dates of service on or after January 1, 2019, Tufts Health Plan will not routinely compensate any anesthesiologist's claim without medical supervision/direction modifiers if a CRNA claim with medical direction has previously been billed.

Modifiers for Anesthesia Services
Effective for dates of service on or after January 1, 2018, Tufts Health Plan does not routinely compensate any code when billed with multiple anesthesia modifiers on the same claim line.

Multiple Anesthesia Services on the Same Day
Tufts Health Plan compensates the primary procedure in conjunction with the time units reported and BUVs associated with that procedure.

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)

DOCUMENT HISTORY
- 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
- September 2015: Template conversion, template updates
- July 2015: Removed epidural injections policy, as these services are included in the Spinal Conditions Management Program, template updates
- May 2015: Added information regarding prior authorization requirements for interventional pain management, effective for dates of service on or after August 1, 2015, removed language regarding E&M services billed in conjunction with a pain management service as it does not apply
- March 2015: Added information regarding CRNAs in New Hampshire, template updates
May 2014: Added policy effective for dates of service on or after July 1, 2014, for evaluation and management services billed with anesthesia services on the same date of service, template updates.

January 2014: Added information regarding anesthesia assistance for Endoscopic Gastrointestinal procedures, added a link to the associated medical necessity guideline, added descriptions of physical status modifiers, template updates

November 2013: Template updates

September 2013: Template Conversion

February 2013: Policy reviewed. Added change in compensation for CRNAs effective for dates of services on or after

April 1, 2013, formatting changes made.

January 2013: Template updates

May 2012: Added change in compensation rate for procedure code 01967, effective for dates of service on or after July 1, 2012 and added anesthesia modifier requirements effective for claims adjudicated on or after July 1, 2012.

January 2012: Removed information regarding Modifier 30.

November 2011: Added procedure code exceptions for time submissions in units and template changes.

June 2011: Added submission requirements for claims submitted in HIPAA 5010 837P format.

December 2010: Added diagnosis code 724.03 to the list of epidural injection diagnosis codes.

May 2010: Added the following: Effective for claims adjudicated on or after July 1, 2010, Tufts Health Plan will only reimburse epidural injections (62311, 64483, 64484) when billed with the following ICD-CM diagnosis codes: 722.10, 724.02, 724.3, 724.4. Reimbursement is limited to a total of four times per year.

June 2009: Clarified that add-on codes will not be reimbursed if the primary procedure code has not been submitted on the same date of service.

May 2008: Revised policy to include a list of anesthesia surgical procedure codes which anesthesiologists are eligible for reimbursement.

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 an office/facility did not comply with this payment policy, Tufts Health Plan will expect the office/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 CareLinkSM 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.