TUFTS Health Plan

Anesthesia Services Payment Policy

Applies to the following Tufts Health Public Plans products:

☒ Tufts Health Direct (a Massachusetts Qualified Health Plan [QHP]; a commercial product)

☒ Tufts Health Together (a MassHealth MCO Plan and Accountable Care Partnership Plans)

☒ Tufts Health RITogether (a Rhode Island Medicaid Plan)

☒ Tufts Health Unify (OneCare Plan; a dual-eligible product)

The following payment policy applies to Tufts Health Plan contracting providers who render services for Tufts Health Public Plans products.

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 federal COVID-19 public health emergency, Tufts Health Plan's payment policy for certified registered nurse anesthetists (CRNAs) are 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 rendered by in-network or out-of-network providers, in accordance with the member's benefits.

DEFINITION

Anesthesia services may include, but are not limited to, general anesthesia, regional anesthesia, supplementation of local anesthesia, or other supportive services that provide members with optimal anesthesia care, as determined by an anesthetist during a procedure. These services include the usual preoperative and postoperative visits, anesthesia care during the procedure, administration of fluids and/or blood during anesthesia or surgery, and the usual monitoring procedure.

Anesthesia time starts when the anesthetist begins to prepare the patient for anesthesia induction in the operating room and ends when the anesthetist is no longer in personal attendance.

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 Tufts Health Public Plans Provider Services.

Note: There is no member responsibility for covered services for Tufts Health Unify, Tufts Health Together or Tufts Health RITogether members.

Tufts Health Plan covers obstetric anesthesia services, including the following:

- Cesarean-section — epidural/spinal block or general anesthesia
- Episiotomy — local anesthesia for performance or repair
- Labor and delivery — paracervical or pudendal block
- Labor and delivery, wider block — epidural, spinal, caudal, or saddle block

REFERRAL/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, Prior Authorization and Notification Policy.

Anesthetists are not required to obtain referrals for anesthesia services performed in conjunction with surgical procedures; however, referrals are required for pain management and nonanesthesia services (e.g., evaluation and management [E&M] services).

Note: All inpatient admissions and surgical day care services require inpatient notification prior to services being rendered.

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.

Providers may bill for anesthesia services on a CMS-1500 form or via electronic data interchange (EDI) using anesthesia code (00100-01999), the appropriate modifier code(s), and start/end times. Tufts Health Plan does not accept CPT surgery codes for professional anesthesia services. For EDI submissions, providers must bill in units, not in minutes. EDI submitters may refer to the most current EDI companion document for the requirements.

COMPENSATION/REIMBURSEMENT INFORMATION

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

Tufts Health Plan acknowledges CMS's definition of medical supervision and direction and only compensates an anesthetist for medical direction services.

Effective for dates of service on or after November 1, 2021, Tufts Health Plan has added the following provider categories to be compensated at 85% of the applicable fee schedule, unless otherwise noted in a provider agreement:

- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetist (CRNA) for services **other** than anesthesia services (00100-01999) billed with modifier QX (qualified non-physician anesthetist with medical direction by a physician)
- Anesthesiologist Assistant

Tufts Health Plan compensates anesthesia using the following formula:

- Billed units equal the time units plus the base unit value, multiplied by the anesthesia conversion factor (rate per unit)
- One time unit is equivalent to 15 minutes of anesthesia time, or a fraction of 15 minutes equal to or exceeding five minutes, up to 15 minutes

The following services are not compensated separately when billed in conjunction with general anesthesia procedures:

- Multiple surgical procedures during a single anesthetic administration. Compensation is determined by the procedure with the highest unit value when multiple surgical procedures are performed during a single anesthetic administration.
- Nerve block injections (64400-64530, 67500)
- Activities considered part of usual anesthesia services, such as:
  - All usual pre- and postoperative services
  - Anesthesia care during the procedure
  - Incidental administration of parenteral fluids and/or blood products
  - Usual monitoring procedures (e.g., ECG, temperature, blood pressure, oximetry, capnography, mass spectrometry)
  - Patient-controlled analgesia (PCA)
- Transesophageal echocardiography when performed during general anesthesia for monitoring purposes
- Inpatient hospital visit codes (CPT code 99xxx series) billed with daily pain management services (01996)
- Placement and insertion of a catheter to administer an epidural on the same day that epidural anesthesia was delivered during surgery. The base value of the anesthesia care includes catheter placement and insertion

- Anesthesia qualifiers, which include qualifying circumstance codes (99100, 99116, 99135, 99140) and physical status modifiers (P1-A to P6-A)
- Regional intravenous administration of local anesthetic agent or medication (01995)
- Daily management of epidural or subarachnoid drug administration (01996)
- Postoperative pain management
- Evaluation and management (E&M) codes for a preoperative consultation unless the surgery is canceled subsequent to the preoperative visit. In that case, payment may be allowed for an E&M code
- Standby anesthesia services

Anesthesia Crosswalk
Tufts Health Plan does not routinely compensate surgical codes billed by anesthesiologists or CRNAs.

Anesthesia Modifiers
Tufts Health Plan does not routinely compensate for the following:

- Codes billed with multiple anesthesia modifiers on the same claim line
- Anesthesia services (00100-01999) billed without an appropriate modifier
- Anesthesia services inappropriately billed with distinct service modifiers

Tufts Health Plan compensates appropriately billed claims submitted with modifiers QK, QY and QX at 50 percent of the allowed amount.

Anesthesia or Postoperative Pain Management Provided by Surgeon
Tufts Health Plan does not routinely compensate for the following:

- Anesthesia services provided by the surgeon
- 01996 (daily management of epidural or subarachnoid drug administration) if billed with 10021-69979 (surgical procedures) by the same provider for the same date of service

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

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

Duplicate Anesthesia Services on the Same Day
Tufts Health Plan does not routinely compensate for the following:

- CRNA services billed with modifier QX or QZ when an anesthesia service performed personally by an anesthesiologist (modifier AA) has been billed for the same date of service.
- Anesthesia codes billed with modifier AA when a CRNA service billed with modifier QX or QZ has been previously paid for the same date of service.[1]

Duplicate Claim Logic for Anesthesia Services by Different Providers
Tufts Health Plan does not routinely compensate duplicate anesthesia service claims when billed by different providers.

E&M Services
Tufts Health Plan does not routinely compensate E&M services (99201-99499) when billed with anesthesia services (00100-01999) the day prior to or the day of surgery.

Maximum Units
Effective for dates of service on or after April 1, 2021, Tufts Health Plan does not routinely compensate anesthesia codes that have exceeded Tufts Health Plan’s daily maximum units allowed.

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.

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[1]Does not apply to RITogether.

Multiple General Anesthesia Services on Same Day[1]
Tufts Health Plan limits coverage of compensation and frequency for multiple general anesthesia service codes (00100-01999) billed for the same day to the code with the highest submitted charge amount.

Obstetric Anesthesia Services
Tufts Health Plan limits compensation for the following obstetric anesthesia services to the maximum allowable times listed below.

Code	Description	Maximum Allowable Time
01961	Anesthesia for Cesarean-section delivery only	120 minutes
01962	Anesthesia for urgent hysterectomy following delivery	120 minutes
01963	Anesthesia for Cesarean-section hysterectomy, without labor analgesia/anesthesia care	240 minutes
01968	Anesthesia for Cesarean-section delivery, following neuraxial labor analgesia/anesthesia care	360 minutes
01969	Anesthesia for Cesarean-section hysterectomy, following neuraxial labor analgesia/anesthesia care	480 minutes

Pain Management Injections
Tufts Health Plan does not routinely compensate anesthesia and moderate sedation services (00300, 00400, 00600, 01935, 01936, 01991, 01992, 99152, 99153, 99156, 99157) if billed with pain management services and billed without a surgical code (10021-69990) by any provider for a member aged 18 years or older on the date of service.

Perioperative Transesophageal Echocardiography (TEE)
Tufts Health Plan does not routinely compensate TEE services in the following circumstances:

- 93318 or 93355 if billed with anesthesia services (00100-01992)
- 93312-93317 if billed without a distinct services modifier when billed with anesthesia services (00100-01992)

Professional Component of Radiology Services in Facility Places of Service
Tufts Health Plan will not routinely compensate professional radiology services when billed by an anesthesiologist in the inpatient or outpatient hospital setting.

ADDITIONAL RESOURCES

- MassHealth Regulation: 101 CMR 316.00: Surgery and Anesthesia

DOCUMENT HISTORY

- May 2022: Added obstetric anesthesia information previously located in the Obstetric Anesthesia Payment Policy
- Jan 2022: Clarified compensation amounts for CRNAs billing for Tufts Health Public Plans members
- September 2021: Effective for dates of service on or after November 1, 2021, additional provider categories added to compensation rate
- January 2021: Added edit for maximum anesthesia units, effective for dates of service on or after April 1, 2021
- November 2018: Added edits for anesthesia for colorectal cancer screening; CRNA services; professional component of radiology services in facility places of service; and medical supervision and medical direction of anesthesia services effective for dates of service on or after January 1, 2019; added compensation information for modifiers QK, QY and QX effective January 10, 2019
- March 2018: Template updates
- November 2017: Added edits for anesthesia for pain management injections, and anesthesia modifiers for anesthesia services effective for dates of service on or after January 1, 2018
- November 2017: Updated to include RITogether; clarified policy, definition and authorization requirements; added previously communicated edits for anesthesia or postoperative pain management provided by surgeon, multiple general anesthesia services on same day, CCI edit for detailed discussion: perioperative transesophageal echocardiography (TEE), anesthesia crosswalk, anesthesia modifiers for anesthesia services, E/M service with anesthesia services,

distinct service modifiers, duplicate anesthesia services on the same day, and duplicate claim logic for anesthesia services by different providers
- July 2017: Added edits for modifiers and E&M services
- February 2017: Template updates

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[SM] 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.