TUFTS Health Plan

Anesthesia Services Payment Policy

Applies to the following Tufts Health Public Plans products:

☒Tufts Health Direct – Health Connector

☒Tufts Health RITogether – A RI Medicaid Plan

☒ Tufts Health Together – Includes MassHealth Plan and Accountable Care Partnership Plans

☒Tufts Health Unify – OneCare Plan

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.

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, as described below.

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.

AUTHORIZATION REQUIREMENTS

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

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 the start and 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

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

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[1].

Anesthesia Modifiers

Tufts Health Plan does not routinely compensate for the following:

- Codes billed with multiple anesthesia modifiers on the same claim line[1]
- Anesthesia services (00100-01999) billed without an appropriate modifier
- Anesthesia services inappropriately billed with distinct service modifiers

Effective for dates of services on or after January 10, 2019, Tufts Health Plan will compensate 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

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).

Colorectal Cancer Screenings

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 surgery code (10000-69999) has not been billed for the same date of service by any provider.

[1] Effective for dates of service on or after January 1, 2018.

Duplicate Anesthesia Services on the Same Day

- Tufts Health Plan does not routinely compensate 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.[1]
- Tufts Health Plan does not routinely compensate 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.[2]

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.

Medical Supervision/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.

Multiple General Anesthesia Services on Same Day[2]

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.

Pain Management Injections

Effective for dates of service on or after January 1, 2018, 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

Effective for dates of service on or after January 1, 2019, 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

- 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

[2]Does not apply to RITogether.

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 your office/facility did not comply with this payment policy, Tufts Health Plan will expect your office/facility to refund all payments related to non-compliance. For more information about Tufts Health Plan's audit policies, refer to our 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.