

**Policy is terminated because coverage is provided under the combined
Medicaid and Health Choice policy 1L-1, Anesthesia Services.**

Table of Contents

| | | |
|-----|--|---|
| 1.0 | Description of the Procedure, Product, or Service..... | 1 |
| 2.0 | Eligible Recipients..... | 1 |
| 2.1 | General Provisions..... | 1 |
| 3.0 | When the Procedure, Product, or Service Is Covered..... | 1 |
| 3.1 | General Criteria..... | 1 |
| 3.2 | Specific Criteria..... | 1 |
| 4.0 | When the Procedure, Product, or Service Is Not Covered..... | 2 |
| 4.1 | General Criteria..... | 2 |
| 4.2 | Specific Criteria..... | 2 |
| 5.0 | Requirements for and Limitations on Coverage..... | 3 |
| 5.1 | Prior Approval..... | 3 |
| 5.2 | Limitations..... | 3 |
| 6.0 | Providers Eligible to Bill for the Procedure, Product, or Service..... | 3 |
| 7.0 | Additional Requirements..... | 3 |
| 7.1 | Compliance..... | 3 |
| 8.0 | Policy Implementation/Revision Information..... | 4 |
| | Attachment A: Claims-Related Information..... | 5 |
| A. | Claim Type..... | 5 |
| B. | Diagnosis Codes..... | 5 |
| C. | Procedure Code(s)..... | 5 |
| D. | Modifiers..... | 5 |
| E. | Billing Units..... | 6 |
| F. | Place of Service..... | 6 |
| G. | Co-payments..... | 6 |
| H. | Reimbursement..... | 6 |

1.0 Description of the Procedure, Product, or Service

Anesthesia is a procedure produced by a number of agents capable of bringing about partial or complete loss of feeling and sensation. The administration may be general, spinal block, or local.

2.0 Eligible Recipients

2.1 General Provisions

To be eligible, NCHC recipients must be enrolled on the date of service.

3.0 When the Procedure, Product, or Service Is Covered

3.1 General Criteria

NCHC covers procedures, products, and services related to this policy when they are medically necessary and

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available; **AND**
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria

- a. Anesthesia is covered when it is administered by an eligible provider (Refer to **b** below) and is determined to be medically necessary.
- b. The following are eligible providers for anesthesia service benefits:
 1. Professional anesthesiologist
 2. Certified registered nurse anesthetist
 3. Anesthesiology assistant under the direction of an anesthesiologist
- c. Anesthesia service is considered to include all services incidental to the anesthesia:
 1. Pre-and post-operative visits
 2. Administration of anesthetic
 3. Fluids and/or blood administered by the anesthesiologist
 4. Drugs and materials provided by anesthesiologist
 5. Interpretation of monitoring procedures

- d. Benefits for general anesthesia are determined as follows:
 1. Anesthesia time starts with the beginning of the administration of the anesthesia agent and ends when the anesthesiologist is no longer in personal and continuous attendance (when the patient may be safely placed under customary post-operative supervision).
 2. Pre-operative, operative, and post-operative anesthesia services are included in the flat charge for general anesthesia, with customary allowances based on the specific procedure base value.
 3. Reimbursement for general anesthesia is based upon the anesthesia base unit value of the procedure code billed. Time allowances are the only variables.
- e. Benefits for anesthesia standby are determined as follows:
 1. Medical necessity must be documented in the medical record by the operating physician.
 2. In situations where the operating physician specifically orders the anesthesia standby in the medical record, and the patient's medical condition is of such a critical nature that general or spinal block anesthesia cannot be safely administered, the Plan will provide medical consultation benefits for the local standby provided by an anesthesiologist when that is the service reported.
 3. Benefits are not available for routine standby or for standby required by hospital or staff rules and regulations during local anesthesia procedures.
- f. No additional base value units may be added to the anesthesia base units when any of the following are necessary and are listed on the claim in conjunction with an anesthetic:
 1. Extracorporeal circulation (open heart surgery when the patient is placed on heart pump bypass)
 2. Total body hypothermia
 3. Controlled hypothermia
 4. Hyperbaric pressurization
 5. Anesthesia complicated by emergency conditions

4.0 When the Procedure, Product, or Service Is Not Covered

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service unnecessarily duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental or investigational.

4.2 Specific Criteria

- a. No anesthesia benefits are provided for administration of local anesthesia or for anesthesia services performed by the operating surgeon or surgical assistant(s).

- b. When a specified surgical procedure is performed and is not a covered service under the NC Health Choice Program, the anesthesia is not covered.
- c. When a surgical procedure that requires prior approval is performed without prior approval, the anesthesia is not covered.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

Prior approval is not required. (Refer to **Subsection 4.2.c**)

5.2 Limitations

- a. Requests for anesthesiologist standby must be documented in the medical records by the operating physician as being medically necessary or no reimbursement will be provided.
- b. No extra units are allowed for either the surgeon, assistant surgeon(s), or the anesthesiologist for the following procedures:
 - 1. Transfusions
 - 2. Intubations
 - 3. Electrical conversion of arrhythmia
 - 4. Arterial cannulizations
 - 5. Other similar procedures

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet NCHC qualifications for participation;
- b. be currently enrolled with NCHC; **AND**
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

7.0 Additional Requirements

7.1 Compliance

Providers must comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

8.0 Policy Implementation/Revision Information

Original Effective Date: July 1, 2010

Revision Information:

| Date | Section Revised | Change |
|--------------|-----------------|--|
| July 1, 2010 | Throughout | Policy Conversion: Implementation of Session Law 2009-451, Section 10.32 “NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY.” |
| 4/30/12 | Throughout | Policy Termination |
| | | |

Attachment A: Claims-Related Information

Reimbursement requires compliance with all NCHC guidelines.

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

C. Procedure Code(s)

| | |
|------------------------------|---------------|
| Anesthesia codes | 00100 – 01999 |
| CPT surgery codes | 10021 – 69990 |
| CPT surgery codes | 90918 – 90999 |
| CPT surgery codes | 93973 – 92975 |
| CPT surgery codes | 92980 – 92998 |
| CPT surgery codes | 93501 – 93545 |
| CPT surgery codes | 93561 |
| CPT surgery codes | 93562 |
| CPT surgery codes | 93580 – 93612 |
| CPT surgery codes | 93618 – 93652 |
| CPT surgery codes | 97780 |
| CPT surgery codes | 97781 |
| Anesthesia qualifiers | 99100 |
| Anesthesia qualifiers | 99116 |
| Anesthesia qualifiers | 99135 |
| Anesthesia qualifiers | 99140 |
| Anesthesia qualifiers | 99143 |
| Anesthesia qualifiers | 99144 |
| Anesthesia qualifiers | 99145 |
| Anesthesia qualifiers | 99148 |
| Anesthesia qualifiers | 99149 |
| Anesthesia qualifiers | 99150 |

D. Modifiers

Must file with appropriate modifier.

| General modifiers | Description |
|-------------------|--|
| 23 | Unusual Anesthesia |
| 47 | Anesthesia by Surgeon (will deny as an incidental procedure) |
| QS | Anesthesiologists or CRNAs may use QS to report monitored anesthesia care (MAC). When MAC is billed, the QS modifier is informational only. Anesthesiologists and CRNAs must also append modifier AA, AD, QZ, QK, QX, or QY. |

| Modifiers billed by anesthesiologist | Description |
|--------------------------------------|--|
| AA | Anesthesia services performed personally by anesthesiologist |
| AD | Medical supervision by a physician: more than 4 concurrent anesthesia procedures |
| QK | Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals. (The anesthesiologist may supervise no more than two anesthesiologist assistants at one time) |
| QY | Medical direction of one CRNA/anesthesiologist assistant by an anesthesiologist |
| Modifiers billed by CRNA | Description |
| QZ | CRNA service: without medical direction by a physician |
| QX | CRNA service: with medical direction by a physician |

Note: 01958 - 01969 are for obstetric anesthesia. As there is no coverage for maternity care for NCHC, these codes are non-covered.

E. Billing Units

Providers must report the time for all general and monitored anesthesia services as 1 minute = 1 unit.

F. Place of Service

Inpatient Hospital, Outpatient Hospital and Office

G. Co-payments

Co-payment(s) may apply to covered prescription drugs and services.

H. Reimbursement

Providers must bill their usual and customary charges.