



Anesthesia Payment Policies

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The procedure codes and fee schedule amounts in this document do not necessarily indicate coverage or payment. All coverage and payments are subject to Offender Health Plan Coverage, exclusions, limitations, and pre-authorization requirements. For detailed coverage information, refer to the Department of Corrections (DOC) *Offender Health Plan, Billing Instructions and Payment Policies*. For directions on submitting claims to ProviderOne, see the ProviderOne Billing and Resource Guide.

Fees in this publication are subject to change without notice. Although we make every effort to ensure the accuracy of the fees in our publications, changes or corrections may occur throughout the year.

Visit the DOC web site at www.doc.wa.gov/business/healthcareproviders to download the latest versions of this fee schedule, and all other DOC publications mentioned in this document.

DOC Anesthesia Payment Policy

Refer to the 2012 CPT® and HCPCS coding books for complete code descriptions

Anesthesia Services Payment Policy

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I. Anesthesia Payment System Overview

Services covered by DOC under this benefit include anesthesia services related to medically necessary surgery or pain management for a covered condition. Please see the current DOC Offender Health Plan (OHP) for specifics on coverage and benefit limits.

DOC pays for anesthesia services according to actual time units and anesthesia base units. For the majority of CPT® anesthesia codes, the anesthesia bases in the DOC payment system are the same as the anesthesia base units adopted by both Medicare and the American Society of Anesthesiologists (ASA). For the CPT® anesthesia codes where Medicare and the ASA bases are different, DOC uses Medicare's anesthesia bases, with a few exceptions.

Payment for some procedures, including pain management services, intubation, Swan-Ganz insertion and placement, and selected surgical services, is based on the DOC Professional Provider Fee Schedule amounts.

II. Anesthesia Procedure Codes

Anesthesia services must be billed with Current Procedural Terminology (CPT®) anesthesia codes 00100 through 01999 with the applicable modifier. The DOC does not accept American Society of Anesthesiologists (ASA) RVG codes that are not included in CPT®. All anesthesia codes should be billed according to the descriptions published in CPT®. If there are differences in code descriptions between CPT® and ASA RVG, the CPT® descriptions will apply. This fee schedule does not contain CPT® code descriptions. For billing purposes refer to a current CPT® coding reference for complete code descriptions.

Some procedures commonly performed by anesthesiologists and CRNAs (such as E&M services and pain management procedures) are not reimbursed according to anesthesia base and time units but instead according to the resource based relative value scale (RBRVS). For payment consideration of these services providers must bill the appropriate CPT® surgery or medicine codes (with no anesthesia modifier). For payment rates for these services, refer to the DOC Professional Provider Fee Schedule located at:

<http://www.doc.wa.gov/business/healthcareproviders/ProfessionalFeeSchedule.asp>

III. Fee Schedule Updates

The Department of Corrections (DOC) primary fee schedule update is scheduled to occur annually in July and will include updates to the DOC anesthesia conversion factor, anesthesia base units, and fees for pain management and other services. A secondary update in January will incorporate added codes and remove deleted codes.

IV. Anesthesia Conversion Factor

The DOC conversion factor for reimbursement of anesthesia services is \$52.56 for dates of service on or after July 1, 2010. The DOC conversion factor is based on a 15-minute unit payment system. Anesthesia services are reimbursed according to actual time units and anesthesia base units.

DOC Anesthesia Conversion Factor: \$52.56 (\$3.504 per minute)

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Refer to the 2012 CPT® and HCPCS coding books for complete code descriptions

V. Anesthesia Base Units

For the majority of the CPT® anesthesia codes, the current anesthesia bases in the DOC payment system are the same as the Centers for Medicare & Medicaid Services (CMS) 2012 anesthesia base units and the American Society of Anesthesiologists (ASA) 2012 anesthesia base units. For the CPT anesthesia codes where CMS and the ASA bases are different, the CMS anesthesia bases are used, with a few exceptions based on feedback from our State Agency Anesthesia Technical Advisory Group.

VI. Anesthesia Time Units

DOC payment for anesthesia is based on a per minute reporting assumption. Providers must report the actual anesthesia minutes calculated to the next whole minute in the "units" field (24G) on the CMS 1500 claim form. The DOC will determine the base units from the procedure code billed.

Anesthesia time begins when the provider starts to physically prepare the offender for the induction of anesthesia in the operating room area (or its equivalent) and ends when the anesthesiologist or CRNA is no longer in constant attendance (when the offender can be safely placed under postoperative supervision).

VII. Maximum Allowance Calculation

In the claims processing system, this is translated into an equivalent per-minute conversion factor (for example, a conversion factor of \$48.00 per 15 minutes would convert to \$3.2000 per minute).

DOC's maximum allowance for payment of anesthesia services is determined as follows:

Step	Maximum Allowance Calculation
1	Multiply anesthesia base units by 15
2	Add total billed minutes to value from step 1
3	Multiply total from step 2 by DOC's per minute conversion factor**

Sample Calculation: Provider billed 120 minutes for a procedure code with 5 base units

Step	Maximum Allowance Calculation	Sample Calculation
1	Multiply anesthesia base units by 15	$5 \times 15 = 75$
2	Add total billed minutes to value from step 1	$75 + 120 = 195$
3	Multiply total from step 2 by DOC's per minute conversion factor**	$195 \times \$3.504 = \683.28

Note: If an anesthesiologist or CRNA personally performs the anesthesia service, DOC pays based on 100 percent of the maximum allowed amount. In a team care situation, where an

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anesthesiologist medically supervises or medically directs CRNA services, DOC payment to both the anesthesiologist and CRNA is based on 50 percent of the total maximum allowance.

Following Medicare's payment policy, providers may sum up blocks of time around a break in continuous anesthesia care, as long as there is continuous monitoring of the offender within the blocks of time. This policy does not alter the fundamental principle that anesthesia time represents a continuous block of time when an offender is under the care of an anesthesiologist or CRNA. DOC does not pay for time units for the pre-anesthesia exam and evaluation, as these services are included in the base unit component.

VIII. Anesthesia Modifiers

For DOC to pay, you must report the applicable anesthesia modifier from the table below with the appropriate anesthesia procedure code. DOC accepts all valid CPT®/HCPCS level II modifiers; however, the modifiers identified in the table are the only ones that affect payment for the anesthesia services

Physician Performing	
AA	Anesthesia service performed personally by anesthesiologist
Physician Directing	
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals
QY	Medical direction of one CRNA by an anesthesiologist
Physician Supervising	
AD	Medical supervision by a physician
CRNA Performing	
QX	CRNA service with medical direction by a physician
QZ	CRNA service without medical direction by a physician

A. Medical direction of anesthesia modifiers (QK and QY).

DOC follows Medicare's payment policy for medical direction of anesthesia services. For each offender, the physician is required to:

- Perform a pre-anesthetic examination and evaluation
- Prescribe the anesthesia plan
- Personally participate in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergency
- Ensure that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual as defined in program operating instructions
- Monitor the course of anesthesia administration at frequent intervals
- Remain physically present and available for immediate diagnosis and treatment of emergencies

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- Provide indicated post-anesthesia care

In addition, the physician may direct no more than four anesthesia services concurrently and may not perform any other services while directing the single or concurrent services. The physician may attend to medical emergencies and perform other limited services (as Medicare allows) and still be deemed to have medically directed anesthesia procedures. The physician must document in the offender's medical record that the medical direction requirements identified above were met.

B. Monitored anesthesia care service

Monitored anesthesia care is reimbursed in the same way as regular anesthesia care, but instead of using the QS modifier, you must bill in the following manner:

- If the physician personally performs the services, bill modifier AA
- If the physician directs four or fewer concurrent procedures and monitored care represents two or more of the procedures, bill modifier QK
- If the CRNA personally performs all of the service, bill modifier QZ
- If the CRNA is medically directed, bill modifier QX

C. Teaching anesthesia services

Modifier AA is recognized on an anesthesiologist's claim in a teaching situation (as long as DOC does not receive a separate claim for professional anesthesia services from any other provider).

D. Patient Acuity Codes/Modifiers

DOC does not adjust the payment level for services provided based on acuity levels. Qualifying circumstances (CPT codes 99100, 99116, 99135, and 99140; Modifiers P3, P4, P5) are considered bundled and are not paid separately.

E. Add-on Anesthesia Procedure Codes

1. Burn Excisions or Debridement

To receive payment from DOC, providers may report the CPT® anesthesia add-on code 01953 in addition to the primary anesthesia code 01952.

Anesthesia provided for second- and third-degree burn excision or debridement should be reported as follows:

- For the primary anesthesia code (01952), report the total anesthesia minutes in the units field (24G)
- For the add-on code (01953), use the units field (24G) to report one unit per 9 percent (or part thereof) of body surface.

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2. Obstetric

You may report the following CPT® add-on codes in conjunction with CPT® code 01967 (neuraxial labor analgesia/anesthesia for planned vaginal delivery) when appropriate. The anesthesia time for the primary and add-on procedures are reported and paid separately:

CPT® Code	Description
01968	Cesarean delivery following neuraxial labor analgesia/anesthesia
01969	Cesarean hysterectomy following neuraxial labor analgesia/anesthesia

3. Anesthesia Payment Limitations for Obstetric Deliveries

DOC's maximum reimbursement per obstetric delivery for epidural anesthesia is equal to 360 minutes (six hours).

IX. Pain Management and Other Services Paid Under the RBRVS Methodology

Some procedures commonly performed by anesthesiologists and CRNAs are reimbursed using the RBRVS maximum allowance, instead of anesthesia base and time units. These services include most pain management services, intubation, Swan-Ganz insertion and placement, as well as other selected surgical services. For DOC to pay, you must bill the applicable CPT® surgery or medicine codes (with no anesthesia modifier). See the DOC Professional Provider Fee Schedule for the maximum allowances for these services.

<http://www.doc.wa.gov/business/healthcareproviders/ProfessionalFeeSchedule.asp>

X. Anesthesia Services Performed by the Surgeon (CPT® Modifier 47)

DOC follows Medicare policy and does not pay separately for local, regional, digital block, or general anesthesia administered by the surgeon.

XI. Billing Manuals and Other DOC Publications

Please refer to the DOC *Billing Instructions for Professional Providers, Facilities and Hospitals* for additional information and billing instructions.

Visit the DOC web site at <http://www.doc.wa.gov/business/healthcareproviders/default.asp> to download copies of all DOC publications mentioned in this document. If you have any questions, please call (360) 725-8298.