Anesthesia Professional Payment Policy

Applies to the following CarePartners of Connecticut products:

- ☒ CareAdvantage Premier
- ☒ CareAdvantage Prime
- ☒ CareAdvantage Preferred
- ☒ CarePartners Access

The following payment policy applies to providers who render anesthesia services to members of the CarePartners of Connecticut plans selected above.

In addition to the specific information contained in this policy, providers must adhere to the policy information outlined in the Professional Services and Facilities Payment Policy.

During the rapidly evolving situation around COVID-19, CarePartners of Connecticut's payment policy for medically necessary anesthesia services is documented in the Coronavirus (COVID-19) Updates for Providers page

Note: Audit and disclaimer information is located at the end of this document.

POLICY

CarePartners of Connecticut covers medically necessary anesthesia services, in accordance with the member's benefits.

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 CarePartners of Connecticut Provider Services at 888.341.1508.

REFERRAL/PRIOR AUTHORIZATION/NOTIFICATION REQUIREMENTS

Certain procedures, items and/or services may require 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.

No referrals are required for in-network services. Referrals are required for out-of-network services rendered for HMO members.

Note: All inpatient admissions require inpatient notification prior to services being rendered. Professional claims may be denied if the notification to the hospital has not been obtained by the facility.

BILLING INSTRUCTIONS

Unless otherwise stated, CarePartners of Connecticut 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.

Use of labs not participating in the member's applicable network(s) may have the unintended consequence of subjecting the member to unnecessary services not ordered by the treating provider or other unreasonable financial exposure. In such circumstances, CarePartners of Connecticut may hold the ordering provider accountable for any inappropriate behavior on the part of the nonparticipating lab that has been selected.

- Submit the total number of minutes to reflect anesthesia services rendered (e.g., submit two hours and ten minutes as 130 minutes). With the exception of CPT codes 01953 and 01996, claims submitted in units will be rejected.

- Report the start and end time for administration of anesthesia. Measurement of anesthesia time begins when the anesthesiologist starts to prepare the patient for anesthesia care in the operating room or in an 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.

Claims Processing for Anesthesia Services
The following formula will be used when calculating time units. Each 15-minute interval is converted to one time unit, rounding to the nearest tenth of a unit (one decimal place).

The chart time must be reported when submitting a paper claim to validate the number of minutes billed and the chart time must be reported in the patient's record.

Note: Do not submit base unit values (BUVs). CarePartners of Connecticut's calculation for compensation includes BUVs.

Multiple Anesthesia Services on the Same Day
Submit the primary anesthesia service as the first claim line.

Separate Evaluation and Management in Place of Attending or Consulting Physician
Submitting a separate E&M service, in place of an attending or consulting physician, 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, reimbursement will be considered for an E&M service.

Certified Registered Nurse Anesthetist (CRNA) Services
CarePartners of Connecticut does not credential certified registered nurse anesthetists (CRNAs) in Connecticut at this time. CarePartners of Connecticut reimburses medically necessary CRNA services when care is provided under the supervision of an in-plan anesthesiologist and billed under the supervising anesthesiologist's provider identification number.

COMPENSATION/REIMBURSEMENT INFORMATION

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

Compensation for anesthesia services is based on standard CMS and American Society of Anesthesiology method pricing: **[(time units + base unit value) 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:

Component	Source of Information
Total number of minutes	Submitted on the claim by the provider
Time units	Submitted on the claim by the provider
Base unit value (BUV)	CMS
Conversion factor	CarePartners of Connecticut compensation rate

Anesthesia for Pain Management Injections
CarePartners of Connecticut 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 for a patient age 18 or older if a surgical code (10021-69990) has not also been billed by any provider.

Colorectal Cancer Screening
CarePartners of Connecticut 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.

CRNA Services
CarePartners of Connecticut will not routinely compensate anesthesia services (00100-01999) billed by a CRNA without the appropriate CRNA modifier (QX or QZ).

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 reimbursement for the surgical procedure.

E&M and Anesthesia Services
CarePartners of Connecticut will not compensate E&M services when billed with anesthesia services, as the E&M service is included in the anesthesia service. CarePartners of Connecticut will consider compensating the E&M service when the appropriate modifier is appended. Refer to the NCCI Policy Manual for additional information.

Epidural Steroid Injections
CarePartners of Connecticut will not routinely compensate epidural steroid injection (62320, 62321, 62322, 62323, 64479-64484, 0228T, 0229T, 0230T, 0231T) when axial spinal pain (back pain) is the only diagnosis.

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

Modifiers for Anesthesia Services
CarePartners of Connecticut does not routinely compensate any code billed with multiple anesthesia modifiers on the same claim line.

Pain Management
CarePartners of Connecticut compensates medically necessary outpatient pain management services; however, E&M services billed in conjunction with a pain management service are not routinely compensated.

Professional Component of Radiology Services in Facility Places of Service
CarePartners of Connecticut does not routinely compensate professional radiology services when billed by an anesthesiologist in the inpatient or outpatient hospital setting.

Qualifying Circumstances
CarePartners of Connecticut will not 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

- January 2021: Added edit for maximum anesthesia units, effective for dates of service on or after April 1, 2021
- December 2020: Added applicable CarePartners Access PPO content, effective for dates of service on or after January 1, 2021
- January 2020: Eliminate referral requirements for in-network providers effective January 1, 2020
- November 2019: Policy reviewed by committee; clarified claim submission requirements for reporting anesthesia minutes
- January 2019: Policy created

AUDIT AND DISCLAIMER INFORMATION

CarePartners of Connecticut 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, CarePartners of Connecticut will expect the provider/facility to refund all payments related to noncompliance. For more information about CarePartners of Connecticut's audit policies, refer to the CarePartners of Connecticut public Provider website.

This policy provides information on CarePartners of Connecticut 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 CarePartners of Connecticut products identified by the checkboxes on page one. CarePartners of Connecticut reserves the right to amend a payment policy at its discretion.