# Anesthesia Professional Payment Policy

Applies to the following CarePartners of Connecticut products:

☒ 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.

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

## Policy

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

## 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. It is the responsibility of the admitting practitioner and/or facility to obtain a referral and/or inpatient notification, as necessary.

## 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.

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.
- If submitting multiple anesthesia services on the same day, submit the primary anesthesia service only with the highest base unit value (BUV). Total time should be submitted for all procedures performed.

### Anesthesia Time Units

The following formula is 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.

If billing for multiple anesthesia services on the same day, submit the primary anesthesia service as the first claim line.

### Separate E&M in Place of Attending/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

Contracting CRNAs may bill directly for services. CRNAs billing for practitioner-directed/supervised CRNA services should submit claims with the appropriate procedure codes, modifier(s), and applicable time units for both the physician and the CRNA on separate claim lines.

Anesthesia services (00100-01999) billed by a CRNA must include the appropriate CRNA modifier to indicate whether services were performed independently or under the supervision/direction of an anesthesiologist.

CRNA services are compensated in accordance with state regulations and CMS guidelines, as applicable.

### Anesthesia Modifiers

Submit one anesthesia modifier per anesthesia service claim line; claim lines billed with multiple anesthesia modifiers will be denied

| Modifier | Description | Notes |
|---|---|---|
| AA | Anesthesia services personally performed by the anesthesiologist | 100% of fee schedule/allowed amount |
| AD | Supervision, more than four procedures | 50% of fee schedule/allowed amount |
| GC | Services performed by a resident under the direction of a teaching physician | Teaching anesthesiologist should report modifiers AA and GC (certification modifier) |
| G8 | Deep complex complicated, or markedly invasive surgical procedures | Used for reporting purposes only |
| G9 | Appended with an anesthesia code to indicate that the patient has a history of a severe cardiopulmonary condition | Used for reporting purposes only |
| P1-P6 | Physical status modifiers | Report in the secondary modifier position |
| QK | Medical direction of two, three, or four concurrent anesthesia procedures | 50% of fee schedule/allowed amount |
| QS | Monitored anesthesia care (MAC) services (can be billed by a qualified nonphysician anesthetist or physician) | Used for reporting purposes only |
| QX | Qualified non-physician anesthetist with medical direction by a physician | 50% of fee schedule/allowed amount |
| QY | Medical direction of one CRNA/AA by an anesthesiologist | 50% of fee schedule/allowed amount |
| QZ | Certified registered nurse anesthetist (CRNA) without medical direction by a physician | 100% of fee schedule/allowed amount |

## Compensation/Reimbursement Information

Providers are compensated according to the applicable contracted rates and applicable fee schedules.

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 |

### Colorectal Cancer Screening

CarePartners of Connecticut does 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

Anesthesia services (00100-01999) billed by a CRNA must include the appropriate CRNA modifier (QX or QZ).

When a CRNA performs anesthesia services under the medical direction and/or supervision of an anesthesiologist, both the anesthesiologist/physician and the CRNA will be compensated at 50 percent of the allowed amount for that service. Compensation will be assigned to the practitioner listed on the claim.

### Conscious Sedation

Conscious sedation is not separately compensated when billed in conjunction with a surgical procedure code, as it is included in the reimbursement for the surgical procedure.

### Epidural Steroid Injections

Epidural steroid injection (62320, 62321, 62322, 62323, 64479-64484, 0228T, 0229T, 0230T, 0231T) is not compensated when axial spinal pain (back pain) is the only diagnosis.

### Maximum Units

CarePartners of Connecticut does not compensate for anesthesia codes that have exceeded our daily maximum unit allowed.

### Pain Management Injections

Daily hospital management of epidural or subarachnoid continuous drug administration (01996) is not compensated when billed more than three days following a general anesthesia service.

### Qualifying Circumstances

The following CPT procedure codes are not compensated:

- 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)

## Additional Resources

- Evaluation and Management Professional Payment Policy
- Surgery Professional Payment Policy

## Document History

- January 2024: Annual policy review; updated modifier grid; administrative updates
- January 2023: Annual policy review; administrative updates
- March 2022: Coding updates; replaced deleted codes 01935-01936 with codes 01937-01942,
- effective for DOS on or after January 1, 2022
- 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.