Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Payment Policy:
Anesthesia

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products
☒ Tufts Health Plan Commercial products

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product)
☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan
☒ Tufts Health One Care – A dual-eligible product

Senior Products

☒ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)
☒ Tufts Medicare Preferred HMO/PPO (Medicare Advantage products)

The following payment policy applies to Tufts Health Plan contracting anesthesiologists rendering anesthesia services in a physician's office, inpatient or outpatient facility.

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, 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 Provider Services.

Referral/Prior Authorization/Notification Requirements

Certain procedures, items and/or services may require referral and/or 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, Authorization and Notification Policy.

Anesthesiologists are not required to obtain referrals for anesthesia services performed in conjunction with a surgical procedure; however, referrals are required for pain management and non-anesthesia services, such as an evaluation and management (E&M) service.

Note: All inpatient admissions require inpatient notification prior to services being rendered. Professional claims will 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.

Outpatient Interventional Pain Management

Providers must request prior authorization for interventional pain management services through National Imaging Associates (NIA). Providers can contact NIA for prior authorization through RadMD.

Note: Prior authorization is not required for interventional pain management spine services rendered in an emergency department, observation, or hospital inpatient setting. Refer to the Spinal Conditions Management Prior Authorization Program for more information.

For a list of CPT codes subject to prior authorization, refer to the Spinal Conditions Management Program Code Matrix.

Billing Instructions

Unless otherwise stated, Tufts Health Plan 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.

- Report the start and end time for administration of anesthesia. Measurement of time begins when the anesthesiologist starts to prepare the patient for anesthesia care in the operating room (or 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.
- Submit the total number of minutes to indicate 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.
- 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.

Claims Processing for Anesthesia Services

During claims processing, submitted minutes are converted into time units.

- **Commercial products:** Each 15-minute interval is converted to one time unit, rounding up to the next unit for 8-14 minutes and rounding down for 1-7 minutes.
- **Senior Products:** Each 15-minute interval is converted to one time unit, rounding to the nearest tenth of a unit (one decimal place).
- **Tufts Health Public Plans:** 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

Note: Do not submit BUVs. Tufts Health Plan's compensation calculation includes BUVs.

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

Certified Registered Nurse Anesthetist (CRNA) Services

CRNAs who contract with Tufts Health Plan may bill directly for services.

When billing for practitioner-directed/supervised CRNA services, anesthesia claims should be submitted with the appropriate procedure code, modifier, and applicable time units for both the physician and the CRNA on **separate** claim lines. The appropriate anesthesia modifier must be submitted to indicate whether the service was personally performed by an anesthesiologist or in conjunction with a CRNA.

Anesthesia Modifiers

As defined in the AMA CPT Manual, "all anesthesia services are reported by use of the anesthesia five-digit procedure code (00100-01999) plus the addition of a physical status modifier. The use of other optional modifiers may be appropriate."

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

Anesthesia Modifiers

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

E&M Services

Submitting a separate E&M service in place of an attending or consulting practitioner 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, compensation will be considered for an E&M service.

Explanation of Payment: The explanation of payment (EOP) will reflect time units for anesthesia services rendered.

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 + BUV) x anesthesia conversion factor

BUVs will automatically be included in the compensation. Pre- and postoperative consultations are considered part of the BUV.

Tufts Health Plan compensates the primary procedure in conjunction with the time units reported and BUVs associated with that procedure.

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)	Obtained from American Society of Anesthesiology (ASA) Guide
Conversion factor	Tufts Health Plan compensation rate

The following provider categories are compensated at 85% of the applicable fee schedule, unless otherwise noted in a provider agreement:

- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetist (CRNA) for services **other** than anesthesia services (00100-01999) billed with modifier QX (qualified non-physician anesthetist with medical direction by a physician)

All Products

Colorectal Cancer Screening

Tufts Health Plan does not routinely compensate 00811 (anesthesia for lower intestinal endoscopic procedures) if billed with modifier PT unless a CPT surgery code (10000-69999) has been billed for the same date of service by any provider.

Conscious Sedation

Conscious sedation is not considered for separate compensation if billed in conjunction with a surgical procedure code, as it is included in the compensation for the surgical procedure.

CRNA Services

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.

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

Maximum Units

Tufts Health Plan does not routinely compensate for anesthesia codes that have exceeded our daily maximum unit allowed.

Modifiers for Anesthesia Services

Tufts Health Plan does not routinely compensate any code when billed with multiple anesthesia modifiers on the same claim line.

Pain Management Injections

Tufts Health Plan does not routinely compensate for daily hospital management of epidural or subarachnoid continuous drug administration (01996) when billed more than three days following a general anesthesia service.

Qualifying Circumstances

Tufts Health Plan does not routinely 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)

Commercial products only

Anesthesia Assistance with Elective Gastrointestinal Endoscopic Procedures

Tufts Health Plan may cover anesthesia assistance for gastrointestinal endoscopic procedures if there is documentation in the member's medical record that certain risk factors and/or a significant medical condition exists. Refer to the Anesthesia Assistance with Elective Gastrointestinal Endoscopic Procedures Medical Necessity Guideline for more information.

Fluoroscopic Procedure Interpretation

Anesthesiologists are eligible for compensation for certain fluoroscopic procedure interpretation codes. For information regarding procedure codes that anesthesiologists are privileged to perform, refer to the Imaging Privileging Program chapter of the Commercial Provider Manual.

When submitted appropriately, anesthesiologists are compensated globally (technical and professional component of these fluoroscopic procedures).

Obstetrical Services

Tufts Health Plan compensates for professional services for CPT code 01967 (analgesia/anesthesia for planned vaginal delivery) at 13 time units (195 minutes), regardless of the number of time units billed. Procedure codes 01967 and 01968 (anesthesia for Cesarean delivery following neuraxial labor analgesia/anesthesia care) are compensated separately.

Senior Products only

Epidural Steroid Injections

Tufts Health Plan does not routinely compensate epidural steroid injection (62320, 62321, 62322, 62323, 64479-64484, 0228T, 0229T, 0230T, 0231T) if axial spinal pain (back pain) is the only diagnosis.

Professional Component of Radiology Services in Facilities

Tufts Health Plan does not routinely compensate professional radiology services billed by an anesthesiologist in the inpatient or outpatient hospital setting.

Tufts Health Public Plans only

Obstetric Anesthesia Services

Tufts Health Plan limits compensation for the following obstetric anesthesia services to the maximum allowable times listed below.

Code	Description	Maximum Allowable Time
01961	Anesthesia for Cesarean-section delivery only	120 minutes

01962	Anesthesia for urgent hysterectomy following delivery	120 minutes
01963	Anesthesia for Cesarean-section hysterectomy, without labor analgesia/anesthesia care	240 minutes
01968	Anesthesia for Cesarean-section delivery, following neuraxial labor analgesia/anesthesia care	360 minutes
01969	Anesthesia for Cesarean-section hysterectomy, following neuraxial labor analgesia/anesthesia care	480 minutes

Additional Resources

- MassHealth Regulation: 101 CMR 316.00: Surgery and Anesthesia
- Evaluation and Management Professional Payment Policy
- Noncovered/Nonreimbursable Services Payment Policy
- Surgery Professional Payment Policy

Publication History

January 2024: Annual policy review; combined Commercial, Senior Products, and Tufts Health Public Plans content into one document

Background and disclaimer information

This policy applies to the products of Harvard Pilgrim Health Care and Tufts Health Plan and their affiliates, as identified in the check boxes on the first page for services performed by contracted providers.

Payment is based on member benefits and eligibility on the date of service, medical necessity review, where applicable, and the provider's network participation agreement with the Plan. 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.

Point32Health reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated as applicable; please adhere to the most recent CPT and HCPCS coding guidelines.

We reserve the right to conduct audits on any provider and/or facility to ensure accuracy and 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, Harvard Pilgrim Health Care and Tufts Health Plan will expect the provider/facility to refund all payments related to noncompliance.