ANESTHESIA SERVICES

PURPOSE

This policy outlines covered, non-covered, and billing requirements related to anesthesia services provided to ND Medicaid members.

APPLICABILITY

Enrolled anesthesiologists and licensed certified registered nurse anesthetists (CRNA).

COVERED SERVICES & LIMITS

Anesthesia services are covered for members undergoing surgical or nonsurgical procedures in an outpatient or inpatient setting where the administration of an anesthetic is required. To provide the care deemed appropriate, the type of anesthesia may be any of the following:

- General anesthesia;
- Regional anesthesia;
- Monitored anesthesia care; and
- Moderate sedation.

GLOBAL SERVICE

Anesthesia is a global service and includes the following:

- Preoperative and postoperative visits;
- Anesthesia care during the procedure;
- Administration of fluids or blood; and
- Usual monitoring services (ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry).

OTHER ANESTHESIA SERVICES

ND Medicaid reimbursement for anesthesia services includes pre- and post-operative visits. If an anesthetic is not administered due to a surgery cancellation, the anesthesiologist or CRNA may bill an Evaluation and Management (E/M) CPT code equivalent to the service performed.

Unusual monitoring forms, such as the placement of intra-arterial and central venous lines and insertion of Swan-Ganz catheters, are not included in the global payment. They are separately reimbursed when billed by anesthesiologists and CRNAs.

Pain management procedures such as post-operative nerve bocks must be conducted face-to-face and limited to one daily service. The appropriate CPT/HCPCS code must be used when billing this service.

Epidural Anesthesia for Vaginal or Cesarean Section

Continuous epidural analgesia for labor and vaginal or cesarean delivery. The CPT code that describes this service includes the epidural catheter placement. The number of minutes the anesthesiologist or CRNA is physically present with the member must be recorded in the unit's box. ND Medicaid payment for CPT 01967 will be capped at a maximum of 75 minutes.

Moderate (Conscious) Sedation

Moderate conscious sedation procedure codes are eligible for separate reimbursement following current CPT and NCCI coding guidelines. Moderate conscious sedation codes are time-based procedure codes. Time must be documented to support the reported codes and units. Moderate conscious sedation does not include minimal sedation (anxiolysis), deep sedation, or monitored anesthesia care, these procedures should be reported under 00100-01999.

MEDICAL DIRECTION

Anesthesiologists can be reimbursed for the personal medical direction, as distinguished from supervision, they furnish to CRNAs. In all cases where the anesthesiologist provides medical direction, he or she must be physically present in the operating suite. Medical direction is a billing distinction describing a higher level of physician involvement than medical supervision. North Dakota Medicaid will cover medical direction services when the anesthesiologist directs CRNAs in two, three, or four concurrent cases and personally performs the following:

- Pre-anesthetic exam and evaluation;
- Prescribes anesthesia plan;
- Personally participates in anesthesia procedures, including induction and emergence;
- Ensures procedures in the anesthesia plan that he/she does not perform are performed by qualified anesthetist;
- Monitors course of anesthesia frequently;
- Remains physically present and available for immediate diagnosis and treatment of emergencies; and
- Provides any indicated post-anesthesia care.

MEDICAL SUPERVISION

Medical supervision occurs when the anesthesiologist is involved in more than four concurrent cases, and only some of the medical directions listed above are performed.

BILLING GUIDELINES

- Anesthesia services must be submitted on a CMS 1500 or 837P transaction.
- The claim must include the exact number of minutes beginning when the anesthesiologist or CRNA prepares the member for induction and ending when the anesthesiologist or CRNA is no longer in personal attendance. The patient can be safely placed under postoperative supervision. ND Medicaid will calculate the base units for each procedure.
- Anesthesia CPT codes must be accompanied by one of the following modifiers:
  AA = Anesthesia services performed personally by anesthesiologist. (This modifier should be used only when the anesthesiologist is involved on a full-time basis in the administration of anesthetic to one patient, with or without the assistance of a CRNA).
  AD* = Medical supervision by a physician: more than four concurrent anesthesia procedures.
  QK* = Medical direction by a physician of two, three, or four concurrent anesthesia procedures.
  QX = CRNA services with medical direction by a physician.
  QY* = Medical direction of one qualified non-physician anesthetist by an anesthesiologist.
  QZ = CRNA services without medical direction by a physician.
  *A payment reduction of 50% applies to this modifier.
- ND Medicaid does not separately reimburse qualifying circumstance CPT codes 99100, 99116, 99135, and 99140.
- Patient Status Modifiers P1-P6 are informational only and do not impact payment.

REIMBURSEMENT

ND Medicaid uses the most recent Centers for Medicare & Medicaid Services (CMS) list of base values. The base value for anesthesia services includes usual pre-operative and post-operative visits.

Time units equal the number of minutes from when the patient is prepared to when the anesthetist is no longer in personal attendance or continues to be required. The time minutes submitted on the claim are divided into 15-minute increments (divide time units by 15).

The formula used for calculating payment on anesthesia claim lines is as follows. (Base units + [time units / 15]) x Conversion factor posted on the Rates and Fee Schedules page.

NON-COVERED SERVICES

- Anesthesia administered in association with a non-covered procedure;
- Supervision or medical direction provided by a physician who is not an anesthesiologist.
- Anesthesia for hysterectomy or sterilization when the proper federal consent has not been obtained.

SUMMARY OF POLICY UPDATES

January 2025

Section	Updates
Covered Services and Limits	Covered services clarified and added limits. Added Global Services section.
Other Anesthesia Services	Added clarification on unusual monitoring forms and nerve blocks.
Medical Direction and Supervision	Sections added.
Billing Services	Added clarification on billing, not separately reimbursed codes, and modifiers P1-P6.
Reimbursement and Non-Covered Services	Sections added.