Medicaid Anesthesia Guidelines and Modifiers

Florida Medicaid reimburses for anesthesia as an adjunct to the following services in accordance with the American Medical Association Current Procedural Terminology, the American Society of Anesthesiologists (ASA), Centers for Medicare and Medicaid Services, National Correct Coding Initiative (NCCI) and the applicable Florida Medicaid fee schedule(s):

- Surgical procedures
- Medical procedures
- Obstetrical procedures
- Dental procedures

Epidural Anesthesia

Florida Medicaid reimburses for up to 360 minutes of epidural anesthesia for a vaginal delivery or a cesarean delivery.

Monitored Anesthesia Care (MAC)

Florida Medicaid reimburses for MAC, when billed with the anesthesia codes, when providers anticipate a recipient may either:

- Require general anesthesia
- Develop an adverse physiological reaction during the surgical procedure

Specific Non-Covered Criteria

Florida Medicaid does not reimburse for the following:

- More than 360 minutes of epidural anesthesia
- Services for medical procedures that are not Florida Medicaid compensable
- Services that are not listed on the fee schedule
- Telephone communications with recipients, their representatives, caregivers, and other providers, except for services rendered in accordance with the Florida Medicaid telemedicine policy

Billing Code

- Providers must include the appropriate code based on the major procedure performed on the claim form.
- Providers must use procedure code 01967 for continuous epidural analgesia during labor and vaginal delivery on the claim form.
- Providers must use procedure code 01967 with the service time, and 01968 with one minute of service time if the service progressed to a caesarian delivery.

Billing Unit

- Providers must include the number of units on the claim form based on the total anesthesia service time. Any portion of a 15-minute increment equals one unit.

The Florida Medicaid Anesthesia Services Coverage Policy states the following:

Payment Calculation

The configuration must also take into consideration the AHCA anesthesia calculations found in the Practitioner Fee schedule which states:

Anesthesia time is reported in total minutes and reimbursed through the below calculation. Qualified non-physician providers, within their scope of practice, are reimbursed at 80%. (Anesthesia FSI, Facility, PCI, or TCI rate) + (time/15 x $14.50) = reimbursement rate.

The Florida Anesthesia Services Coverage Policy:
http://ahca.myflorida.com/medicaid/review/specific_policy.shtml

The Florida Practitioner Fee Schedule:
http://ahca.myflorida.com/medicaid/review/fee_schedules.shtml

Example:

Anesthesia FSI base rate is $72.49
Minutes: 148

Billed minutes 148/15 minutes = 10 (9.866666666 rounded)
$72.49 (Anesthesia FSI) + (10 X $14.50) = reimbursement rate
$72.49 + $145 = $217.49

Pediatrics
Billed minutes 148/15 minutes = 10 (9.866666666 rounded)
$72.49 x (Anesthesia FSI plus appropriate increases) + (10 X $14.50) = reimbursement rate
$72.49 (1.04) (1.24) + ($145) = reimbursement rate
$93.48 + $145 = $238.48

Modifiers

Providers must include the following modifiers, as appropriate, on the claim form:

- 78 Unplanned return to the operating room, related procedure
- QK Physician supervision of anesthesia
- QS MAC

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Utilizing the AHCA Anesthesia Coverage and Limitations Handbook, Centers for Medicare & Medicaid Services (CMS) and American Society of Anesthesiologist (ASA)guidelines, we updated our Anesthesia Guidelines. In sum, Anesthesiologist and Anesthetist must bill the appropriate modifiers in order to receive proper payment of claims and are required. If not billed, the claim should deny.

Per the CMS - https://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center and within the Medicare Claims Processing Manual (Chapter 12; Physician/Nonphysician Practitioner) it states:

Physicians report the appropriate modifier to denote whether the service meets the requirements for payment at the personally performed rate, medically directed rate, or medically supervised rate.

A list of modifiers and definition is explained within the same CMS processing manual.

Furthermore, the CMS Anesthesia Center points to the American Society of Anesthesiologist and the American Association of Nurse Anesthetists which defines the use of modifier and gives the below example:

Dr. A medically directs CRNA A in providing anesthesia care to a patient for removal of her gall bladder. This is one of three concurrent cases.

- *CPT Code*
  00790 - Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; not otherwise specified
- *HCPCS Modifiers*
  *Dr A reports **QK** - Medical Direction of two, three or four concurrent anesthesia procedures involving qualified individuals*
  *CRNA A reports the same CPT code with modifier **QX** - Qualified nonphysician anesthetist service: With medical direction by a physician*

Dr. B personally provides anesthesia care for a patient undergoing a total right knee replacement.

- *CPT Code*
  01402 - Anesthesia for total knee arthroplasty
- *HCPCS Modifier*
  ***AA** - Anesthesia Services performed personally by the anesthesiologist*

Note: *Florida Practitioner File explains:*

- *Services provided by an APRN or a PA within their scope of practice may be billed under a physician's Medicaid provider number when the physician is in the building and able to render assistance as needed. These services are reimbursed at the physician allowable amount.*
- *Services provided within the APRN's and PA's scope of practice that are performed when the physician is not in the building, must be billed under the rendering APRN's or PA's Medicaid provider number and are reimbursed at 80% of the allowable amount*

For the reason and as it relates to the % when modifiers are billed for these midlevel specialties. The modifier where 100% reimbursement is determined, the 100% reimbursement = 80% and the 50% reimbursement = 40%

Anesthesia Modifiers & Descriptions

Anesthesia Modifiers	Description	Reimbursement Percentage
AA	Anesthesia Services performed by the anesthesiologist	100% CMS Language: *The physician and the CRNA (or anesthesiologist's assistant) are involved in one anesthesia case and the services of each are found to be medically necessary. Documentation must be submitted by both the CRNA and the physician to support payment of the full fee for each of the two providers. The physician reports the AA modifier and the CRNA reports the QZ modifier.* *In unusual circumstances when it is medically necessary for both the CRNA and the anesthesiologist to be completely and fully involved during a procedure, full payment for the services of each provider is allowed. The physician would report using the AA modifier and the CRNA would report using the QZ modifier. Documentation must be submitted by each provider to support payment of the full fee.*
AD	Medical Supervision by a physician, more than 4 concurrent anesthesia procedures	100%

QK	Medical direction of two, three, four concurrent anesthesia procedures involving qualified individuals	50% CMS Language: *The A/B MAC determines payment at the medically directed rate for the physician on the basis of 50 percent of the allowance for the service performed by the physician alone. Payment will be made at the medically directed rate if the physician medically directs qualified individuals (all of whom could be CRNAs, anesthesiologists' assistants, interns, residents, or combinations of these individuals) in two, three, or four concurrent cases and the physician performs the following activities.*
QX	Qualified non-physician anesthetist services: with medical direction by a physician	*50%* CMS Language: *Where a single anesthesia procedure involves both a physician medical direction service and the service of the medically directed qualified nonphysician anesthetist, the payment amount for the service of each is 50 percent of the allowance otherwise recognized had the service been furnished by the anesthesiologist alone. For the single medically directed service, the physician will use the QY modifier and the qualified nonphysician*

		anesthetist will use the QX modifier.
QY	Medical direction of one qualified non-physician anesthetist by an anesthesiologist	50% Claim Language: *Where a single anesthesia procedure involves both a physician medical direction service and the service of the medically directed qualified nonphysician anesthetist, the payment amount for the service of each is 50 percent of the allowance otherwise recognized had the service been furnished by the anesthesiologist alone. For the single medically directed service, the physician will use the QY modifier and the qualified nonphysician anesthetist will use the QX modifier.*
QZ	CRNA service: Without medical direction by a physician	100% CMS Language: *The physician and the CRNA (or anesthesiologist's assistant) are involved in one anesthesia case and the services of each are found to be medically necessary. Documentation must be submitted by both the CRNA and the physician to support payment of the full fee for each of the two providers. The physician reports the AA modifier and the CRNA reports the QZ modifier.*

		In unusual circumstances when it is medically necessary for both the CRNA and the anesthesiologist to be completely and fully involved during a procedure, full payment for the services of each provider is allowed. The physician would report using the AA modifier and the CRNA would report using the QZ modifier. Documentation must be submitted by each provider to support payment of the full fee.
QS	Monitored anesthesia care services. This modifier is for informational purposes.	N/A - informational
22	Increased Procedural Services	N/A - informational
78	Unplanned Return to Operating/Procedure Room by the same physician	N/A - informational
G8	Monitored anesthesia care for deep complex, complicated, or markedly invasive surgical procedures	N/A - informational
G9	Monitored anesthesia care for patient who has a history of severe cardio-pulmonary condition	N/A - informational

Additional Resources

Medicare Claims Processing Manual Chapter 12
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

American Society of Anesthesiology
https://www.asahq.org/quality-and-practice-management/managing-your-practice/timely-topics-in-payment-and-practice-management/anesthesia-payment-basics-series-codes-and-modifiers

If you have questions, please contact Molina Healthcare at: 855-322-4076
Thank you for your continued care to our members!
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