JOHNS HOPKINS HEALTH PLANS	Johns Hopkins Health Plans **Provider Relations and Network Innovation Reimbursement Policy**	*Policy Number*	RPC.007
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This document applies to the following Participating Organizations:

EHP	Johns Hopkins Advantage MD	Priority Partners	US Family Health Plan

Keywords: ASA, Obstetrical Anesthesia

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I. ABOUT OUR REIMBURSEMENT POLICIES

The most current version of the reimbursement policies can be found on www.hopkinsmedicine.org.

Johns Hopkins Health Plan LLC (JHHP) reimbursement policies serve as a guide to assist in accurate claim submissions and outline the basis for reimbursement of services covered by a member's JHHP benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a guarantee that you will be reimbursed. Services must meet prior authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence. Providers are expected to and must follow proper billing and submission guidelines. Providers are required to use industry standard, compliant codes on all claim submissions. Services must be billed with valid ICD-10 diagnosis codes, Healthcare Common Procedure Coding System/Current Procedural Terminology (HCPCS/CPT) codes, place of service (POS) codes, and/or revenue codes as defined by the Centers for Medicare & Medicaid Services (CMS) and in the American Medical Association's (AMA's) "CPT Manual".

The codes billed should denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the patient's medical record and/or office notes and JHHP reserves the right to request the records. Issues related to inconsistent, missing, conflicting, or unclear documentation must be resolved by the provider submitting the claim. If a corrected claim is filed, it must comply with timely filing to be reprocessed through the claims system. Corrected claims are for administrative errors on the claim (i.e., misspelled name, CPT/HCPCS code transposed, wrong DOB, missing modifier, etc.). Intentionally changing the CPT/HCPCS or diagnosis code in order to get the claim paid, after the billed service was denied, is not a correction. The medical records must match the services billed. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

JHHC policies apply to all practitioners, hospitals, providers, or suppliers eligible to bill the relevant HCPCS/CPT codes pursuant to applicable portions of the Social Security Act (SSA) of 1965, the Code of Federal Regulations (CFR), and

Medicare rules. JHHC reimbursement policies are developed based on nationally accepted industry standards, coding principles, and follows CMS guidelines and the CMS developed National Correct Coding Initiative (NCCI) program to prevent inappropriate payment of services that should not be reported together. These policies may be superseded by mandates in provider or state contracts, or state, federal or CMS contracts and/or requirements. If appropriate, when coding/billing guidelines or current reimbursement policies are not followed, JHHC may:

- Reject or deny the claim
- Recover and/or recoup claim payment

JHHC reserves the right to modify policies at any time and publish new versions when necessary. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, JHHC strives to minimize these modifications. When there is an update, policies will be published on our website.

II. PURPOSE

To provide basic reimbursement guidance on anesthesiology services for both participating and nonparticipating providers submitting claims to JHHP. Providers must bill for the reimbursement of anesthesia services that are within the provider's scope of practice under state and federal law. Each line of business possesses its own unique contract and guidelines for benefit and payment purposes. As such, there could be various factors that may impact reimbursement, including but not limited to legislative mandates, provider contracts, and/or the member's benefit coverage, including provisions addressing services rendered by non-participating providers, which may supplement, modify, or supersede this policy.

III. POLICY STATEMENT

Claims submitted for anesthesia services are reimbursed differently from other procedure codes. JHHP requires providers to report the appropriate anesthesia CPT codes 00100 – 01999, each of which encompasses all of the anesthetic care associated with a family of related surgical procedures. Each line of business possesses its own unique guidelines for benefit and payment purposes. When applicable, JHHP may align with regulatory, state and federal guidance to identify physician and non-physician services that are eligible as reimbursable or non-reimbursable, as applicable to the member's plan.

*Providers are responsible to review the **"EXCEPTIONS & EXCLUSIONS" Sections** below for specific plan guidance, as some guidelines in this policy may not be applicable to all health plans/products.*

IV. BILLING GUIDELINES AND PAYMENT METHODOLOGY

1. Unless otherwise specified in this policy, minutes are to be reported on the claim for anesthesia services.
   i. Providers must report the anesthesia start and stop times.
   ii. Some anesthesia services are not time-based and are excluded from this requirement.
2. The appropriate and required modifier(s) for anesthesia services must be reported, and in the correct order, or the service will be denied.
   i. The appropriate modifier must be appended to the post-operative pain management procedure code to indicate if a distinct procedural service was performed.
3. Anesthesia time begins when the anesthesiologist or CRNA personally begins to prepare the patient for anesthesia care in the operating room or in an equivalent area. Anesthesia time ends when the anesthesiologist or CRNA is no longer in constant, personal attendance, and the patient has been safely placed under post-anesthesia supervision, either in the post-anesthesia care unit (PACU) or an intensive care unit.
4. No separate payment will be made for anesthesia services rendered by the operating surgeon, physician or nurse anesthetist who also performs the medical or surgical service for which the anesthesia is required, as anesthesiology services are included in the surgical allowance.

5. When acupuncture is used as a method of anesthesia for a covered surgical procedure performed by a qualified, licensed physician (other than the attending physician), benefits are provided in accordance with the member's contract.
6. Anesthesia claim must identify who provided the anesthesia. In those cases where part of the anesthesia service is provided by an anesthesiologist and the remainder by a nonphysician anesthetist, the claim(s) must identify exactly the services provided by each type of provider, so that the appropriate payment level can be used.
7. In certain circumstances, additional payment rules and limitations may apply to anesthesia services when a surgery is canceled or delayed.

V. INAPPROPRIATE BILLING of ANESTHESIA SERVICES

1. It is standard medical practice for an anesthesia practitioner to perform a patient examination and evaluation prior to surgery and postoperatively. E/M examinations are not to be reported separately from the anesthesia time as these services are considered part of the anesthesia service.
2. In accordance with NCCI guidelines, providers/suppliers shall not report drug administration CPT codes 96360-96377 for anesthetic agents or other drugs administered between the patient’s arrival at the operative center and discharge from the post-anesthesia care unit.
3. The practice expense portion includes medical and/or surgical supplies and equipment commonly furnished in a practice and are a usual part of the anesthesiology service. As such, incidental services are not eligible for reimbursement.
4. Consistent with CMS, the provider/supplier shall not unbundle the anesthesia procedure and report component codes individually.
   - Introduction of a catheter/needle (CPT 36000) is considered incidental to all anesthesia services and are not eligible for reimbursement.
5. For interval time periods during which the patient does not require monitoring by an anesthesia practitioner, this time would not be included in the anesthesia time calculation. However, if it is medically necessary for the anesthesia practitioner to continuously monitor the patient during the interval time, and not perform any other service, the interval time may be included in the anesthesia time, but must be clearly documented in the patient’s medical record.
6. Management of epidural or subarachnoid drug administration (CPT code 01996) is separately payable on dates of service after surgery, but not on the date of surgery.
   - CPT code 01996 is not considered anesthesia services according to the American Society of Anesthesiologists (ASA) Relative Value Guide (RVG) and should not be reported as time-based services.
   - If the only service provided is management of epidural/subarachnoid drug administration, then an E&M service shall not be reported in addition to CPT code 01996.
   - Payment for CPT 01996 is limited to one unit of service per postoperative day regardless of the number of visits necessary to manage the catheter per postoperative day.
7. In alignment with CMS guidance, the physician performing an operative procedure is responsible for treating postoperative pain and treatment of postoperative pain by the operating physician is not separately reportable. However, if the operating physician requests that an anesthesia practitioner assist in the treatment of postoperative pain management, it must be medically reasonable and necessary. The actual or anticipated postoperative pain must be severe enough to require treatment by techniques beyond the experience of the operating physician.

VI. BASE ANESTHESIA UNIT VALUES

1. For services that do not include “Base Value Units”, additional benefits may be provided for these procedures/services, as they are not considered “included” in the base anesthesia unit value, and may be reported separately, if appropriate.

- *Example of services that are not considered included in base unit values*: Placement of Swan Ganz catheters, arterial lines, central venous pressure (CVP) lines, and lines to the superior or inferior vena cava. The specific CPT Codes are: 93503, 36420, 36425, 36620, 36625, 36555-36556, 36557-36558.

VII. OBSTETRICAL (OB) ANESTHESIA SERVICES

1. In accordance with the ASA Relative Value Guide, unlike operative anesthesia services, there is no single, widely accepted method of accounting for time for neuraxial labor anesthesia services (CPT 01967). As such, JHHP will subject these services to a reasonable cap of 360 minutes, which includes insertion through delivery. JHHP will calculate as follows:
   - One unit of CPT 01967 per 15 minutes for the first hour of anesthesia (4 units total), plus one unit of CPT 01967 per hour after the 1st hour (5 units) up to the maximum of 360 minutes (9 units), is allowed.
   - Providers may submit additional documentation for the consideration of additional reimbursement of time in excess of 360 minutes. However, additional payment to be determined by JHHP.
2. Reporting of add-on codes CPT 01968 and 01969 when billed with CPT 01967, is limited to the first hour of 01967.
3. Labor anesthesia services includes the intensity and time involved in performing and monitoring any neuraxial labor anesthesia service.
   - Delivery may include related services such as delivery of placenta or episiotomy/laceration repair.
4. "Anesthesia time" means the time in minutes during which the anesthesia provider is both furnishing continuous anesthesia care to a patient and must be **physically** present with the patient.
5. All OB anesthesia services must be submitted using minutes. Providers are to report total minutes and start and stop times.
6. See ASA guide for appropriate reporting of CPT codes 01960-01969, not specifically addressed in this policy.
7. Clear documentation of any visits/evaluations/encounters with the patient by the anesthesiologist or anesthetist during labor or delivery must be noted in the medical record and must be available if requested. This includes, but is not limited to, documentation of catheter placement(s), administration of medications, visits to assess effectiveness of analgesia, attendance at delivery, and post-partum follow-up care.

VIII. CODES WITH QUALIFYING CIRUMSTANCES

Many anesthesia services are provided under particularly difficult circumstances, depending on factors such as extraordinary condition of patient, notable operative conditions, and/or unusual risk factors. The table below includes a list of qualifying circumstances that significantly affect the character of the anesthesia service provided.

1. Qualifying circumstance CPT codes 99100-99140 would not be reported alone as these codes are considered Add-On Codes (AOC) and must be reported as an additional procedure under a qualifying anesthesia procedure or service.
2. In accordance with CMS reimbursement methodologies, status B codes are bundled into another procedure and are not eligible for separate reimbursement.
3. Each line of business possesses its own unique contract and guidelines for benefit and payment purposes applicable to "Qualifying Circumstances", therefore additional payment or benefits may not apply.

Add-On Code	Code Descriptor
+99100	Anesthesia for patient of extreme age, younger than 1 year and older than 70 (List separately in addition to code for primary anesthesia procedure).

+99116	Anesthesia complicated by utilization of total body hypothermia (List separately in addition to code for primary anesthesia procedure).
+99135	Anesthesia complicated by utilization of controlled hypotension (List separately in addition to code for primary anesthesia procedure).
+99140	Anesthesia complicated by emergency conditions (specify) (List separately in addition to code for primary anesthesia procedure).

IX. EXCEPTIONS and EXCLUSIONS

A. **EHP and AdvantageMD:**
- JHHP does not recognize “Qualifying Circumstances” when CPT codes 99100-99140 are billed for our AMD and EHP members.
- JHHP does not allow additional units for physical status modifiers.
- Only one anesthesia code is reported unless the anesthesia code is an AOC. In this case, both the code for the primary anesthesia service and the anesthesia AOC are reported according to “CPT Manual” instructions.
- To report MAC cases, anesthesiologists are to use the QS modifier in addition to reporting the actual anesthesia time and one of the payment modifiers on the claim.

B. **EHP**: Time units are 15 minutes and any fraction of a unit is considered a whole unit. Time units must be submitted on the claim.
- Providers who submit incorrect units or the incorrect type of unit, may result in claim denial, incorrect payment or a delay in claim processing.

C. **PPMCO:** JHHP will process and reimburse claims in accordance with Code of Maryland Regulations (COMAR) and the Maryland Department of Health (MDH) guidance. Please consult the authoritative guidance found on these entities' websites, to obtain additional specific information on policy, benefits, and coverage not addressed in this reimbursement policy.
- Priority Partners does not reimburse anesthesia in the same way as Medicare. Anesthesia claims are reimbursed in accordance with COMAR and MDH guidance.
- JHHP will not make additional payments for participant risk factors, such as participant age, health status (CPT Physical Status Modifiers or Qualifying Circumstance procedure codes), or for monitored anesthesia care (MAC).
- No separate payment will be made for the medical supervision of a CRNA by a physician.
- JHHP requires all providers (i.e., ordering, referring, rendering, servicing, billing) delivering services to Maryland Medicaid members to have an active enrollment status in the electronic Provider Revalidation and Enrollment Portal (ePREP) on the date of service.
- Claims submitted by individual providers, provider groups and facilities who are inactive or unregistered in ePREP will not be reimbursed.

D. **USFHP:** JHHP will process and reimburse anesthesia claims in accordance with TRICARE guidance. Please consult the authoritative guidance found in the TRICARE Manuals to obtain additional, specific information on policy, benefits, and coverage.
- Refer to the TRICARE Policy Manual for the specific requirements for state licensure and certification and their associated reimbursement methodologies for anesthesia services.

X. CODES, TERMS and DEFINITIONS

Definition of Terms

Term	Definition
Add-On Code (AOC)	An Add-on Code is a Healthcare Common Procedure Coding System (HCPCS) / Current Procedural Terminology (CPT) code that describes a service that is performed in conjunction with the primary service by the same practitioner. An AOC is rarely eligible for payment if it's the only procedure reported by a practitioner. On the Medicare Physician Fee Schedule Database, an AOC generally has a global surgery period of "ZZZ."
Anesthesia Base Units	Base units are assigned to the anesthesia CPT and ASA codes, and are defined as the value for each anesthesia code that reflect all activities other than anesthesia time including, but not limited to, the usual pre-and post-operative examinations or visits, administration of fluids/ blood incidental to anesthesia care, and routine monitoring procedures.
Anesthesia Services	Anesthesia services include, but are not limited to, preoperative evaluation of the patient, administration of anesthetic, other medications, blood, and fluids, monitoring of physiological parameters, and other supportive services.
Anesthesia Time	For the purpose of the policy, JHHP defines "Anesthesia time" as the period of time during which the anesthesia provider is both furnishing continuous anesthesia care to a patient **and** is physically present with the patient. Time starts when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the patient (i.e., when the patient may be placed safely under postoperative care). Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service.

Evaluation and Management (E/M) Services	Per the CPT manual, E/M services (CPT 99202-99499) guidelines have sections that are common to all E/M categories and sections that are category specific. These guidelines are to be used by the reporting physician or other qualified healthcare Professional to select the appropriate level of service. The E/M section of the CPT® manual is divided into broad categories and further divided into sub-categories of E/M services.
Monitored Anesthesia Care (MAC)	Monitored anesthesia care involves the intra-operative monitoring by a physician or qualified individual under the medical direction of a physician or of the patient's vital physiological signs in anticipation of the need for administration of general anesthesia or of the development of adverse physiological patient reaction to the surgical procedure. It also includes the performance of a pre-anesthetic examination and evaluation, prescription of the anesthesia care required, administration of any necessary oral or parenteral medications (e.g., atropine, demerol, valium) and provision of indicated postoperative anesthesia care. Modifiers applicable to monitored anesthesia care are G8, G9 and QS.
Medically Unlikely Edit (MUE)	An MUE is the maximum units of service (UOS) reported for a HCPCS/CPT code on the vast majority of appropriately reported claims by the same provider/ supplier for the same member on the same date of service.
Physician or Other Qualified Health Care Professional	A Physician or Other Qualified Health Care Professional is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.
Post-Operative Evaluation Services	Routine post-operative evaluation is included in the base unit for the anesthesia service. If the evaluation occurs under postoperative care, neither additional anesthesia time units nor E/M codes shall be reported for this evaluation.
Same Group Physician and/or Other Qualified Health Care Professional	All physicians and/or other qualified health care professionals of the same group who report with the same Federal Tax Identification Number (TIN). Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician.

Scope of Practice	Scope of practice refers to those activities that a person licensed to practice as a health professional is permitted to perform, which is increasingly determined by statutes enacted by state legislatures and by rules adopted by the appropriate licensing entity.
Time Units	For the purpose of this policy, anesthesia time units are added to the base units to obtain total anesthesia units for the operative session.
Qualifying Circumstance Codes	Qualifying circumstance codes (99100, 99116, 99135 and 99140) are considered add-on codes to a primary anesthesia service code. Many anesthesia services are provided under particularly difficult circumstances, depending on factors such as extraordinary condition of patient, notable operative conditions, and/or unusual risk factors. A qualifying circumstances is that which significantly affects the character of the anesthesia service provided. These procedures would not be reported alone but would be reported as additional procedure numbers qualifying an anesthesia procedure or service.

CPT Codes

CPT Codes	Definition
00100 – 01999	Please refer to the AMA CPT book for all anesthesia procedures. Each code may have specific guidelines, or the codes may include specific details.
99202-99499	Please refer to the AMA CPT book for all E/M CPT descriptors located in the Evaluation and Management section (99202-99499). There are many code categories. Each category may have specific guidelines, or the codes may include specific details.

Anesthesia Modifiers: Physicians are to 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.

Modifier	Definition
AA	Anesthesia Services performed personally by the anesthesiologist.
AD	Medical Supervision by a physician; more than four concurrent anesthesia procedures.
G8	Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedures.

G9	Monitored anesthesia care for a patient who has a history of severe cardio-pulmonary condition.
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals.
QS	Monitored anesthesia care service.
QX	CRNA service: with medical direction by a physician.
QY	Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist.
QZ	CRNA service: without medical direction by a physician.

Physical Status Modifiers: Are informational modifiers that can only be appended to anesthesia service/procedure codes CPT 00100 through 01999.

Modifier	Definition
P1	A normal healthy patient
P2	A patient with mild systemic disease
P3	A patient with severe systemic disease
P4	A patient with severe systemic disease that is a constant threat to life.
P5	A moribund patient who is not expected to survive without the operation.
P6	A declared brain-dead patient whose organs are being removed for donor purposes.

XI. REFERENCES

This policy has been developed through consideration of the following:

- American Society of Anesthesiologists (ASA)
- COMAR- Maryland Department of Health- Maryland Medicaid Administration
- CPT Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association
- Maryland Medicaid Professional Services Provider Manual
- Medicare Claims Processing Manual CH. 1 - General Billing Requirements
- Medicare Claims Processing Manual Chapter 12
- NCCI for Medicare | CMS
- National Provider Identifier Standard (NPI) website
- NCCI for Medicaid | CMS
- TRICARE Reimbursement Manual

XII. REVISION HISTORY

Date	Review or Revision	Reason for Modification	Approved By
10/17/2024	Revison	Updated policy language, guidance and references	Reimbursement Policy Committee (RPC)
10/01/2016	Revision	Updated policy language, guidance and references	Reimbursement Policy Committee (RPC
11/14/2014	Review	Guidance Reviewed	Reimbursement Policy Committee (RPC
07/11/2011	Revision	Updated policy language, guidance and references	Reimbursement Policy Committee (RPC
1/01/2009	New Policy	N/A	Reimbursement Authorizations and Coding Committee (RAC)