

The following payment policy applies to Tufts Health Plan<sup>®</sup> commercial contracted anesthesiologists rendering anesthesia services in a physician's office, inpatient or outpatient facility.

This policy applies to commercial<sup>1</sup> products. For information on Tufts Medicare Preferred HMO's policies and procedures, [click here](#).

**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.

## General Benefit Information<sup>2</sup>

Services and subsequent payment are based on the member's benefit plan document. Providers and their office staff are required to use self-service channels to verify effective dates and copayments for commercial members prior to initiating services.

Reference the [Electronic Services](#) section of our website for our self-service channel options. Benefit specifics should be verified prior to initiating services by logging on to our [website](#) or by contacting [Provider Services](#).

## Member Responsibility

Copayments, deductible and/or coinsurance may apply depending upon the member's benefit plan specifics.

Tufts Health Plan recommends not billing the member for the coinsurance and/or deductible amount until the claim has processed so that the appropriate member responsibility can be determined. Both the provider's Statement of Account (SOA) and the Electronic Remittance Advice (ERA) will reflect the member's responsibility amount.

## Authorization Requirements

Reference the [Authorization Policy](#) for specific preregistration, referral and authorization requirements.

### **Services Requiring Prior Authorization**

Depending upon the service, while you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

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.

It is the responsibility of the admitting physician or surgeon and/or the hospital/facility to obtain a referral and/or preregistration as necessary.

**Note:** All inpatient admissions require preregistration prior to services being rendered. Professional claims will be denied if the preregistration to the hospital has not been obtained.

---

<sup>1</sup> Commercial products include [HMO, POS, PPO & CareLink<sup>SM</sup>](#) when Tufts Health Plan is Primary Administrator

<sup>2</sup> Eligibility is subject to retroactive reporting of disenrollment.

Some procedures require prior authorization with the Tufts Health Plan Precertification Department. Reference the [Clinical Resources](#) section of our website for a list of procedures, services and items that require prior authorization. Reference the [CareLink<sup>SM</sup> Prior Authorization List](#) for a list of procedures, services and items requiring prior authorization for CareLink members.

For a complete description of Tufts Health Plan's commercial authorization requirements, reference the Authorization section within the [Tufts Health Plan Commercial Provider Manual](#).

## General Billing Information

- Submit the most updated industry-standard codes.
- Submit a [modifier](#) when appropriate, with the corresponding CPT and/or HCPCS procedure code(s).
- Submit the appropriate CPT anesthesia procedure codes (00100-01999) and ICD-9 diagnosis code(s).
- 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 non-billable time.

**Note:** Annually and quarterly, HIPAA medical code sets<sup>3</sup> undergo revision by CMS, AMA and CCI. Revisions typically include adding, deleting or redefining the description or nomenclature of new HCPCS, CPT procedure and ICD-9 diagnosis codes. As these revisions are made public, Tufts Health Plan will update its system to reflect these changes.

## EDI Claim Submitter Information

- Submit claims in HIPAA compliant 837P format for professional services. Claims billed with non-standard codes will reject if billed electronically.

## Billing With HIPAA 5010 Compliant 837P Format

- Submit the total number of minutes to indicate anesthesia services rendered..
- For example, if the total time of anesthesia services is two (2) hours and ten (10) minutes, services should be submitted as 130 minutes.
- Claims submitted in units will be rejected.

**Note:** Procedure codes 01953 and 01996 will be accepted when submitted in units and are subject to Tufts Health Plan's [Maximum Units](#) Payment Policy.

## **Claims Processing for Anesthesia Services**

During claims processing, submitted minutes will be converted into time units. The following formula will be used when calculating time units:

Every 15-minute interval will be converted by Tufts Health Plan to 1 unit, rounding up to the next unit for 8 to 14 minutes, rounding down for 1 to 7 minutes.

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). **Tufts Health Plan's calculation for compensation includes BUVs.**

---

<sup>3</sup> HIPAA medical code sets include HCPCS, CPT Procedure and ICD-9 diagnosis codes.

## Billing With HIPAA 4010 Compliant 837P Format

- Submit the total number of minutes to reflect anesthesia services rendered.
- Claims may also be submitted using the appropriate number of time units to indicate anesthesia services rendered based on Tufts Health Plan's guideline for calculating units defined in this policy.

## Paper Claim Submitter Information

- Submit claims on a CMS-1500 form for professional services. Claim line(s) billed with non-standard codes will deny.
- Submit the total number of minutes to reflect anesthesia services rendered.
- Claims submitted in time units will be accepted.

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). **Tufts Health Plan's calculation for compensation includes base unit values (BUVs).**

### **Calculating Time Units for Anesthesia Services**

The following formula should be used when calculating time units:

Submit 1 unit for every 15-minute interval, rounding up to the next unit for 8 to 14 minutes, rounding down for 1 to 7 minutes.

### **Multiple Anesthesia Services on the Same Day**

Submit the primary anesthesia service as the first claim line.

### **Separate Evaluation and Management in Place of Attending or 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 pre-operative evaluation and no anesthesia was administered.

Submitting an E&M procedure code for a pre-operative consultation is not appropriate unless the surgery is cancelled subsequent to the pre-operative visit. In this case, compensation will be considered for an E&M service.

### **Certified Registered Nurse Anesthetists (CRNA) Services**

Tufts Health Plan does not credential CRNA providers in Massachusetts at this time. Tufts Health Plan compensates medically necessary CRNA services, when care is provided under the supervision of an in-plan anesthesiologist and billed under the supervising anesthesiologist's provider identification number.

### **Anesthesia for Obstetrical Services**

Tufts Health Plan applies a 16-time unit (240 minute) maximum limitation for procedure code 01967 (analgesia/anesthesia for planned vaginal delivery).

## Processing Information

Tufts Health Plan will translate anesthesia modifiers to modifier 30 or append a modifier 30 to the anesthesia procedure code when no modifier has been submitted in order to process the claim. In these instances, modifier 30 will be reflected on the SOA or ERA.

It is imperative that providers do not append a modifier 30 or any other non-standard modifier to anesthesia procedure codes. Claims submitted with non-standard modifiers will deny if billed as a paper claim or will reject if billed electronically. For additional information regarding modifiers, reference the Tufts Health Plan Modifier Payment Policy.

## Compensation/Reimbursement Information

Providers are compensated according to the Tufts Health Plan network contracted rates regardless of where the service is rendered. Claims are subject to payment edits that are updated at regular intervals and generally based on CMS standards/guidelines, specialty society guidelines, drug manufacturers' package label inserts and the National Correct Coding Initiative (CCI).

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-operative and post-operative consultations are considered part of the BUV.

The following table identifies the source of each component that is utilized in anesthesia method pricing.

<b>Component</b>	<b>Source of Information</b>
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

### **Multiple Anesthesia Services for the Same Day**

Tufts Health Plan will include the total number of anesthesia time units in the first anesthesia line submitted on the claim. Compensation for the anesthesia services is based on the time units reported plus the BUV. The BUV will only be added to the primary service. BUVs are not added to the secondary procedure code(s).

**Note:** Procedure codes 01967 (analgesia/anesthesia for planned vaginal delivery) and 01968 (Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia. List separately in addition to code for primary procedure performed) are compensated separately.

### **Conscious Sedation**

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

### **Pain Management**

Tufts Health Plan compensates medically necessary outpatient pain management services; however, Tufts Health Plan does not compensate E & M services when billed in conjunction with a pain management service.

### **Fluoroscopic Procedure Interpretation**

Anesthesiologists are eligible for compensation for certain fluoroscopic procedure interpretation codes. Reference the Imaging Privileging Tables located in the Tufts Health Plan Imaging Privileging Program Chapter of the [Tufts Health Plan Commercial Provider Manual](#) for information regarding the procedure codes that anesthesiologists are privileged to perform.

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

### **Qualifying Circumstances**

Tufts Health Plan will not 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)

### **Add-On Codes**

Tufts Health Plan will not compensate add-on code(s) if the primary procedure code has not been submitted on the same date of service. Add-on codes pertain to services performed in conjunction with a primary procedure and should never be reported as a stand-alone service. Reference the AMA CPT manual for additional information.

### **Evaluation & Management and Anesthesia Services**

Tufts Health Plan will not compensate E&M services when billed with anesthesia services, as the E&M service is included in the anesthesia service. Tufts Health Plan will consider compensating the E&M service when the appropriate [modifier](#) is appended. Reference the National Correct Coding Policy Manual for additional information.

### **Anesthesia Surgical Exceptions**

Anesthesiologists are eligible for compensation for some surgical CPT procedure codes at the network contracted rate. Reference the [Anesthesia Surgical Procedure Code List](#) for a list of these surgical CPT procedure codes.

### **Column I (Comprehensive) and Column II (Component) Codes**

Correct Coding Initiative (CCI) has identified comprehensive procedure codes and their associated component codes. Component codes are considered part of the more global comprehensive code and are not eligible for compensation when billed with the comprehensive code. Reference the [CCI Policy Manual](#) for additional information.

### **Epidural Injections**

Tufts Health Plan will only compensate epidural injections (62311, 64483, 64484) when billed with the following ICD-9 diagnoses codes: 722.10, 724.02, 724.03, 724.3, 724.4. Coverage is limited to a total of four times per year.

### **Statement of Account (SOA)**

The SOA is sent to all providers to provide information on the status of the claim(s) submitted to Tufts Health Plan. The SOA indicates status of claims payments, denials and pending claims.

If the procedure code(s) submitted is not used in processing, the SOA will reflect the actual procedure code(s) utilized by Tufts Health Plan to process the claim.

Effective January 1, 2012, paper Statements of Account and the Summary of Account on Tufts Health Plan's secure Provider website will no longer display embedded procedure code modifiers or any Tufts Health Plan unique characters.

The SOA will reflect time units for anesthesia services rendered.

### **Electronic Remittance Advice (ERA)**

The HIPAA compliant 835 ERA is an EDI transaction that providers may request to electronically post paid and denied claims information to their accounts receivable system.

When an industry-standard code(s) is submitted and accepted by Tufts Health Plan, the electronic remittance advice will reflect the code(s) submitted and the actual procedure code(s) utilized by Tufts Health Plan for claims processing.

## Document History

May 2008: Revised policy to include a list of anesthesia surgical procedure codes which anesthesiologists are eligible for reimbursement.

June 2009: Clarified that add-on codes will not be reimbursed if the primary procedure code has not been submitted on the same date of service.

May 2010: Added the following: **Effective for claims adjudicated on or after July 1, 2010**, Tufts Health Plan will only reimburse epidural injections (62311, 64483, 64484) when billed with the following ICD-9 diagnoses codes: 722.10, 724.02, 724.3, 724.4. Reimbursement is limited to a total of four times per year.

December 2010: Added diagnosis code 724.03 to the list of epidural injection diagnosis codes.

June 2011: Added submission requirements for claims submitted in HIPAA 5010 837P format.

November 2011: Added procedure code exceptions for time submissions in units and template changes.

### Audit and Disclaimer Information

Tufts Health Plan 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 your office/facility did not comply with this payment policy, Tufts Health Plan will expect your office/facility to refund all payments related to non-compliance.

This policy provides information on Tufts Health Plan claims adjudication processing guidelines. As every claim is unique, the use of this policy is not a guarantee of payment nor a final prediction 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 guidelines when applicable, adherence to plan policies and procedures and claims editing logic.

This policy does not apply to Tufts Medicare Preferred HMO or Private Health Care Systems (PHCS) network also known as Multiplan members. This policy applies to CareLink when CIGNA HealthCare is Primary Administrator for providers in Massachusetts and Rhode Island service areas for pricing purposes only. Providers in the New Hampshire service area are subject to CIGNA HealthCare's provider arrangement for the purpose of CareLink members.