MEDICAID POLICY INFORMATION SHEET

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Initial ☐ Public Comment ☒ Final ☐

Brief description of policy:

This bulletin updates and clarifies Medicaid coverage and reimbursement for specified anesthesia services with a corresponding revision to the Practitioner chapter of the MDHHS Medicaid Provider Manual, Section 2 – Anesthesia Services. Coverage of services provided by certified registered nurse anesthetists (CRNA) is updated to align with MCL 333.17210, which modifies the CRNA scope of practice to allow qualified CRNAs to provide services independent of physician supervision. This bulletin also references reimbursement methodologies for anesthesia services for provider awareness.

Reason for policy (problem being addressed):

To update and clarify program coverage of anesthesia services.

Budget implication:

☒ budget neutral
☐ will cost MDHHS $, and (select one) budgeted in current appropriation
☐ will save MDHHS $

Is this policy change mandated per federal requirements?

No

Does policy have operational implications on other parts of MDHHS?

Claims processing.

Does policy have operational implications on other departments?

No.

Summary of input:

☐ controversial
☒ acceptable to most/all groups
☐ limited public interest/comment

Supporting Documentation:

State Plan Amendment Required: ☐ Yes ☒ No If Yes, please provide status: ☐ Approved ☐ Pending ☐ Denied Date: Approval Date:	Public Notice Required: ☐ Yes ☒ No If yes, Submission Date:

DRAFT FOR PUBLIC COMMENT Michigan Department of Health and Human Services		
	Project Number: 2330-Practitioner	**Date:** June 14, 2023

Comments Due: July 19, 2023
Proposed Effective Date: September 1, 2023
Direct Comments To: Lisa DiLernia
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Policy Subject: Updates and Clarification to Coverage and Reimbursement of Anesthesia Services

Affected Programs: Medicaid, Healthy Michigan Plan, Maternity Outpatient Medical Services, MI Health Link, Children's Special Healthcare Services

Distribution: Hospitals, Practitioners, Dental Providers, Ambulatory Surgical Centers

Summary: This bulletin updates and clarifies Medicaid coverage and reimbursement for specified anesthesia services with a corresponding revision to the Practitioner chapter of the MDHHS Medicaid Provider Manual, Section 2 – Anesthesia Services. Coverage of services provided by certified registered nurse anesthetists (CRNA) is updated to align with MCL 333.17210 which modifies the CRNA scope of practice to allow qualified CRNAs to provide services independent of physician supervision.This bulletin also references reimbursement methodologies for anesthesia services for provider awareness.

Purpose: To update and clarify program coverage of anesthesia services.

Cost Implications: None.

Potential Hearings & Appeal Issues: None anticipated.

State Plan Amendment Required: Yes ☐ **No** ☒ **If yes, date submitted:**	**Public Notice Required: Yes** ☐ **No** ☒ **Submitted date:**
Tribal Notification: Yes ☐ **No** ☒ **- Date:**	

THIS SECTION COMPLETED BY RECEIVER

☐ **Approved**	☐ **No Comments**
	☐ **See Comments Below**
☐ **Disapproved**	☐ **See Comments in Text**

Signature:	**Phone Number**
Signature Printed:	
Bureau/Administration *(please print)*	**Date**

Proposed Policy Draft

Michigan Department of Health and Human Services
Behavioral & Physical Health and Aging Services Administration

Distribution: Hospitals, Practitioners, Dental Providers, Ambulatory Surgical Centers

Issued: August 1, 2023 (Proposed)

Subject: Updates and Clarification to Coverage and Reimbursement of Anesthesia Services

Effective: September 1, 2023 (Proposed)

Programs Affected: Medicaid, Healthy Michigan Plan, Maternity Outpatient Medical Services, MI Health Link, Children's Special Healthcare Services

This bulletin updates and clarifies Medicaid coverage and reimbursement for specified anesthesia services. In addition, this bulletin updates coverage of services provided by licensed registered professional nurses with the specialty certification of nurse anesthetist in accordance with MCL 333.17210. The information in this bulletin is effective for dates of service on and after September 1, 2023.

Anesthesia Providers

Medicaid covers anesthesia and analgesia services associated with Medicaid covered surgeries and other procedures when provided by qualified health care professional acting within their professional scope of practice and within the requirements of State law and facility policy. Practitioners qualified to administer anesthesia may include the following:

- Physician;
- Dentist;
- Podiatrist;
- Certified registered nurse anesthetist (CRNA); or
- Certified anesthesiology assistant (AA) providing anesthesia services under the supervision of an anesthesiologist.

The anesthesia provider is responsible for the anesthesia care package, which consists of pre-operative evaluation, standard preparation and monitoring services, administration of anesthesia, blood products and fluids, post-anesthesia recovery care, and supportive services. There is no separate coverage for anesthesia services performed by physicians who are also performing the medical or surgical service requiring the anesthesia. Any anesthesia service provided personally by the surgeon is included in the reimbursement for the surgical procedure itself.

Certified Nurse Anesthetist

CRNA anesthesia and analgesia services may be covered when provided within the supervision requirements established by State law as applicable. Supervising providers (physicians, dentists, and podiatrists) must be Medicaid enrolled providers. Pain management services provided by a CRNA in a freestanding pain clinic may only be covered when provided under the supervision of a Medicaid enrolled physician. (Refer to the Practitioner chapter of the MDHHS Medicaid Provider Manual for additional information regarding coverage and reimbursement for CRNA services.)

Levels of Sedation/Analgesia

The continuum of anesthesia services, from least intense to most intense in complexity is as follows: local or topical anesthesia, moderate (conscious) sedation, regional anesthesia, and general anesthesia. MDHHS recognizes the following definition of general anesthesia and levels of sedation/analgesia:

- Minimal Sedation (Anxiolysis) - drug-induced state during which individuals respond normally to verbal commands. Although cognitive function and physical coordination may be impaired, airway reflexes, and ventilatory and cardiovascular functions are unaffected.
- Moderate Sedation/Analgesia (Conscious Sedation) – drug-induced depression of consciousness during which individuals respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. During moderate sedation the responsible physician typically assumes the dual role of performing the procedure and supervising the sedation.
- Deep Sedation/Analgesia - drug-induced depression of consciousness during which individuals cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Individuals may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.
- General Anesthesia - drug-induced loss of consciousness during which individuals are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Individuals often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Reimbursement Methodology for Anesthesia Services

The fee schedule rate calculation for anesthesia services (Current Procedural Terminology [CPT] codes 00100 to 01999) is, with the exceptions noted below, based on the sum of the allowable anesthesia base units and anesthesia time units (i.e., time reported in min/15)

multiplied by the State anesthesia conversion factor. Pricing modifier adjustments are then applied. Reimbursement will be the calculated fee screen or the provider's charge, whichever is less. No additional reimbursement will be made for beneficiary risk factors such as age or health status.

Anesthesia Base Units

Anesthesia base units represent the value assigned by the Center for Medicare & Medicaid Services (CMS) to each anesthesia CPT code. Anesthesia base units account for all other activities other than anesthesia time which include usual pre-operative, intraoperative, and post-operative visits, administration of fluids and/or blood products incident to anesthesia care, and monitoring services. The anesthesia base units for each surgical procedure are specified in the anesthesia fee schedule and should not be included in the reported time units (quantity).

Anesthesia Time Units

Anesthesia time is defined as the period during which an anesthesia practitioner is furnishing continuous anesthesia care to the beneficiary. Time starts when the anesthesia provider begins to prepare the beneficiary for induction of anesthesia and continues throughout the case and while the anesthesia provider accompanies the beneficiary to the post-anesthesia care. Time stops when the provider releases the beneficiary to the care of the post-anesthesia care area personnel. In counting anesthesia time when an interruption in the anesthesia service occurs, only the actual time furnishing anesthesia care is counted. Anesthesia start and stop times must be documented in the medical record. Providers are to report actual anesthesia time in minutes ON CLAIMS FOR REIMBURSEMENT.

The evaluation and examination of the beneficiary prior to surgery is considered part of the anesthesia service and included in the base unit value of the anesthesia code and is not to be reported in the anesthesia time.

Reimbursement of Anesthesia Services

Anesthesia HCPCS/CPT codes include all services integral to the anesthesia procedure such as preparation, monitoring, intra-operative care, and post-operative care until the beneficiary is released by the anesthesia practitioner to the care of another physician or other qualified health care professional.

Anesthesia Billing Modifiers

Billing modifiers must be reported for each anesthesia service billed to Medicaid and will determine the level of reimbursement for anesthesia services. Each claim line for anesthesia services must include one of the modifiers described in the table below. The modifier will generate a calculated fee screen as described under "Special Instructions."

Modifier	Description	Special Instructions and Reimbursement
AA	Anesthesia services performed personally by an anesthesiologist	Reimbursement for anesthesia services reported with CPT codes 00100-01999 will be reimbursed at 100 percent.
AD	Medical supervision by a physician: more than four concurrent anesthesia procedures	Reimbursement for anesthesia services reported with CPT codes 00100-01999 will be a flat rate calculated using the base units multiplied by the State anesthesia conversion factor.
QK	Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals.	Reimbursement for anesthesia services reported with CPT codes 00100-01999 will be reimbursed at 50 percent.
QS	Monitored anesthesia care service	Informational only. Report in addition to payment associated anesthesia modifiers when Monitored Anesthesia Care (MAC) is provided. Modifier QS, used for informational purposes, must be reported as the second modifier on the claim line. If QS is the only anesthesia modifier reported, the claim will be rejected.
QX	CRNA/AA with medical direction by a physician	Reimbursement for anesthesia services reported with CPT codes 00100-01999 will be reimbursed at 50 percent. Anesthesiologist Assistant must be medically directed by an anesthesiologist.
QY	Medical direction of one CRNA/AA by an anesthesiologist	Reimbursement for anesthesia services reported with CPT codes 00100-01999 will be reimbursed at 50 percent.
QZ	CRNA service: without medical direction by a physician	Reimbursement for anesthesia services reported with CPT codes 00100-01999 will be reimbursed at 100 percent. Report for CRNAs practicing independently and for nonmedically directed services.

Anesthesia Add-On Codes

Anesthesia add-on CPT codes (e.g., 01953) are covered in addition to the primary anesthesia code. Reimbursement is a flat rate calculated using the base units multiplied by the State anesthesia conversion factor. Exceptions are obstetric anesthesia add-on CPT codes 01968 and 01969 which are reimbursed utilizing base units, *time* and the State anesthesia conversion factor.

Refer to the Billing & Reimbursement for Professionals and the Practitioner chapter of the MDHHS Medicaid Provider Manual for additional information related to reimbursement of professional anesthesia services.

Coverage of Anesthesia Services

Medically Directed Anesthesia Services

Medicaid covers anesthesia services provided by physicians (anesthesiologist), CRNAs, and AAs for medically directed anesthesia services consistent with anesthesia team practice. (Refer to the Certified Registered Nurse Anesthetist Section and/or the Anesthesiologist Assistant Section of this policy for additional information). Medicaid recognizes medical direction of general anesthesia, regional anesthesia, and reasonable and medically necessary MAC.

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:

- The pre-anesthetic examination and evaluation;
- Prescribes the anesthesia plan;
- Personally participates in the most demanding services in the anesthesia plan including, if applicable, induction and emergence;
- Ensures that a qualified individual performs any services in the anesthesia plan that the physician does not personally perform;
- Monitors the course of anesthesia administration at frequent intervals;
- Remains physically present and available for immediate diagnosis and treatment of emergencies; and
- Provides indicated post-anesthesia care.

Physicians must document in the beneficiary's medical record that they performed the pre-anesthetic exam and evaluation, provided indicated post-anesthesia care, was present during some portion of the anesthesia monitoring, and present during the most demanding services, including induction and emergence, where indicated. Total anesthesia time must be documented in the medical record. The pre-anesthetic exam and post-anesthesia evaluation is included in payment for the medically directed services and generally not separately reimbursed.

*Anesthesiologist assistants must be medically directed by a Medicaid-enrolled anesthesiologist and must comply with the requirements for the delegation and supervision of services in the Michigan Public Health Code.

Physicians cannot medically direct more than four concurrent anesthesia cases at one time. Concurrency refers to the maximum number of procedures that the physician is medically directing within the context of a single procedure and whether these other procedures overlap each other. Concurrency is not dependent on only the cases involving a Medicaid beneficiary but the entirety of the number of medically directed cases.

A physician who is providing medical direction of anesthesia care generally cannot provide additional services to other patients. Addressing an emergency of short duration in the immediate area, administering an epidural or caudal anesthetic to ease labor pain, periodic (rather than continuous) monitoring of an obstetrical patient, receiving patients entering the operating suite for the next surgery, checking or discharging patients in the recovery room, or handling scheduling matters do not substantially diminish the scope of control exercised by the physician and do not constitute a separate service for the purpose of determining whether the requirements for payment at the medically directed rate are met. However, if the physician leaves the immediate area of the operating suite for other than short durations or devotes extensive time to an emergency case or is otherwise not available to respond to the immediate needs of the surgical patients, the physician's services to the surgical patients are supervisory in nature, and therefore, are not paid under the fee schedule.

In select instances, medically directed anesthesia services are covered when provided by a physician who is monitoring more than four concurrent anesthesia services, or who is performing other services while directing the concurrent services, as medically supervised services. The physician must personally provide the pre-anesthesia exam and evaluation, prescribe the anesthesia plan, and be in the operating suite during the entire procedure. A flat rate payment may be made to cover the physician's involvement in the pre-surgical anesthesia services.

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If physicians are in a group practice, one physician member may provide the pre-anesthesia examination and evaluation while another fulfills the other criteria. Similarly, one physician member of the group may provide post-anesthesia care while another member of the group furnishes the other component parts of the anesthesia service. However, the medical record must indicate that the services were furnished by physicians and identify the physicians who furnished them.

Non-Medically Directed Anesthesia Services by the CRNA

Anesthesia services provided by the independent CRNA or CRNA under the supervision of the surgeon or other physician who is immediately available, are covered as non-medically directed anesthesia services. MDHHS reimburses CRNAs for these services if all the following conditions are met:

- CRNA services are provided in accordance with supervision requirements established by state law.
- The facility in which the services are rendered ensures that the anesthesia services are provided in a well-organized manner.
- The facility is responsible for all anesthesia administered in the facility.
- The CRNA provided a pre-anesthetic exam and evaluation within 48 hours prior to the surgery.
- An intra-operative anesthesia record identifies the CRNA providing the anesthesia service and the supervising physician, where applicable.
- The CRNA completes a post-anesthesia follow-up report within 48 hours after surgery for inpatients.

- For outpatients, a post-anesthesia evaluation for proper anesthesia recovery is performed in accordance with the policies and procedures approved by the medical staff.

There is no separate coverage for physicians for any portion of non-medically directed anesthesia services. The physician's supervisory service is included in the facility charge. The pre-anesthetic exam and post-anesthesia evaluation is included in payment for the non-medically directed CRNA care and is generally not separately reimbursed. Reimbursement for the non-medically directed anesthesia service provided by the CRNA is made to the CRNA or the legal entity employing the CRNA.

Monitored Anesthesia Care

MAC is a specific anesthesia service performed by a physician, non-medically directed CRNA, other qualified anesthesia practitioner under the medical direction of a physician, for a diagnostic or therapeutic procedure or in anticipation of the need for administration of general anesthesia. Services may include varying levels of sedation, awareness, analgesia and anxiolysis as necessary. MAC does not describe the continuum of depth of sedation.

MAC is covered on the same basis as other anesthesia services if it is reasonable and medically necessary. MAC includes all aspects of anesthesia care including a pre-procedure assessment and optimization, intraprocedural care including the administration of sedatives, analgesics, hypnotics, anesthetic agents, or other medications as necessary, and post-procedural management. Indications for monitored anesthesia care include, but are not limited to, the nature of the procedure, the patient's clinical condition and/or the need for deeper levels of analgesia/sedation than can be provided by moderate sedation (including potential conversion to a general or regional anesthetic).

Moderate Sedation Services

Moderate Sedation services (e.g., CPTs 99151-99157) are reimbursed utilizing the annual Resource Based Value Scale (RBRVS) multiplied by the State conversion factor. Rates are published on the Physician/Practitioner/Medical Clinics fee schedules. Codes representing moderate sedation are not to be reported for the administration of minimal sedation, deep sedation, general anesthesia or monitored anesthesia care (CPT codes 00100-01999).

<u>Coverage of Anesthesia Services for Specific Procedures</u>

Medical Services

Separate coverage is available for certain medical or surgical services furnished by a provider while furnishing anesthesia services to the beneficiary. The services may be furnished in conjunction with the anesthesia procedure to the beneficiary or as single services (e.g., the day of or the day before the anesthesia service). These services include insertion of a Swan Ganz catheter, insertion of central venous pressure lines, emergency intubation, and critical care. Separate coverage is not available for medical or surgical services, such as the pre-

anesthetic examination of the beneficiary, pre- or post-operative visits, or usual monitoring functions, that are ordinarily included in the anesthesia service.

Anesthesia Performed in Conjunction with Services that Require Prior Authorization

If a surgical procedure requires prior authorization (PA), the surgeon is responsible for obtaining the authorization to perform the service. The anesthesia provider is not responsible for providing proof that the surgical procedure was authorized. (Refer to the General Information for Providers chapter of the MDHHS Medicaid Provider Manual for information regarding PA of services.)

Post-Operative Pain Management

Post-operative pain management is the responsibility of the surgeon (except in special circumstances) and is covered as part of the global service provided by the surgeon.

Placement of a continuous epidural to manage post-operative pain is separately covered under the appropriate CPT/HCPCS code (e.g., CPT 01996) when the anesthesia practitioner performed the service for post-operative pain management and the procedure was not used as the mode of anesthesia for the surgery. Daily management of a continuous epidural on subsequent post-operative days is covered under the appropriate procedure code.

Electro-Convulsive Therapy

Anesthesia services related to electro-convulsive therapy (ECT) are covered by the beneficiary's Prepaid Inpatient Health Plan (PIHP)/Community Mental Health Services Program (CMHSP) or Medicaid Health Plan (MHP). The attending physician must obtain authorization from the PIHP/CMHSP or the MHP. Payment is made by the PIHP/CMHSP or MHP that authorized the service.

Labor and Delivery

Coverage of anesthesia services associated with labor and delivery is based on the type of anesthesia provided. If anesthesia is provided by placement of an epidural catheter, it is covered under the appropriate anesthesia code depending on the type of delivery. The coverage for this service includes any needle placement, drug injection, and any replacement of the epidural catheter during labor. If endotracheal or general anesthesia is provided for the delivery, it is covered under the appropriate anesthesia code. If an epidural catheter is inserted for labor and delivery but it is later necessary to provide endotracheal anesthesia for the delivery, the surgical code for the epidural insertion is covered in addition to the anesthesia service code for the delivery. The medical record must fully document the circumstances requiring both types of anesthesia.

Time for obstetric epidural anesthesia during labor and vaginal and cesarean section deliveries begins with insertion and ends with removal of the epidural catheter. Anesthesia time for sterilization is added to the time for the delivery when the two procedures are performed during the same operative session.

Hysterectomy and Sterilization

By federal statute, all services, including anesthesia services related to hysterectomies or sterilization procedures, must be supported by an informed consent that meets Medicaid consent requirements before the service can be rendered. It is the responsibility of the operating surgeon to obtain this consent. (Refer to the Practitioner chapter of the MDHHS Medicaid Provider Manual, Surgery – Special Considerations section for additional information for hysterectomies and sterilizations.)

Special Considerations

Multiple Anesthesia Services

Report the anesthesia code with the highest Base Unit Value when multiple surgical procedures are performed during a single anesthesia administration. The time reported is the combined total for all procedures performed on the same beneficiary on the same date of service by the same or different physician or other qualified health care professional.

Discontinued Anesthesia Services

In the instance a procedure is cancelled or discontinued after general or regional anesthesia induction has occurred, report the anesthesia base code corresponding to the surgical procedure plus the time expended providing the anesthesia service in minutes.

When a procedure is cancelled after the pre-operative evaluation, reimbursement may be made to the anesthesiologist or the independent CRNA when the appropriate Evaluation and Management (E&M) code is reported.

Teaching Services

Medicaid covers anesthesia services consistent with Medicare guidelines when provided under an attending provider relationship in a teaching hospital and/or in accordance with the coverage and reimbursement guidelines established by the Medicare policies for teaching practitioners.

Services Provided in the Ambulatory Surgical Center

The Ambulatory Surgical Center (ASC) facility payment does not include the anesthesia provider’s professional services. Claims for the provider’s professional services must be submitted on a separate and distinct claim from the ASC facility claim. (Refer to the Ambulatory Surgical Centers chapter of the MDHHS Medicaid Provider Manual for additional information.)

The fee schedule for anesthesia services is published at www.michigan.gov/medicaidprovdiers >> Billing & Reimbursement >> Provider Specific Information >> Physicians/Practitioners/Medical Clinics.