moda HEALTH	Reimbursement Policy Manual	Policy #:	RPM033
Policy Title:	Qualifying Circumstances for Anesthesia		
Section:	Anesthesia	Subsection:	None

Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:

Companies:	☒ All Companies: Moda Partners, Inc. and its subsidiaries & affiliates ☐ Moda Health Plan ☐ Moda Assurance Company ☐ Summit Health Plan ☐ Eastern Oregon Coordinated Care Organization (EOCCO) ☐ OHSU Health IDS
Types of Business:	☒ All Types ☐ Commercial Group ☐ Commercial Individual ☐ Commercial Marketplace/Exchange ☐ Commercial Self-funded ☐ Medicaid ☐ Medicare Advantage ☐ Short Term ☐ Other: _____
States:	☒ All States ☐ Alaska ☐ Idaho ☐ Oregon ☐ Texas ☐ Washington
Claim forms:	☒ CMS1500 ☐ CMS1450/UB (or the electronic equivalent or successor forms)
Date:	☒ All dates – For Medicaid & Medicare Advantage ☒ Specific date(s): For Commercial claims: 2/25/2016 & following ☐ Date of Service; For Facilities: ☐ n/a ☐ Facility admission ☐ Facility discharge ☒ Date of processing
Provider Contract Status:	☒ Contracted directly, any/all networks ☒ Contracted with a secondary network ☒ Out of Network

Originally Effective:	1/1/2000	Initially Published:	8/14/2013
Last Updated:	7/13/2022	Last Reviewed:	7/13/2022
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)?		No	
Last Update Effective Date for Texas:		7/13/2022	

Reimbursement Guidelines

A. Commercial lines of business

Effective for claims processed on or after 2/25/2016, Moda Health does not separately reimburse for CPT codes 99100 – 99140. This is based on their status indicator of "B" (bundled code) on the CMS Physician Fee Schedule.

CPT codes 99100 – 99140 will deny to provider liability with denial codes:

EX:	2M0	Service/supply is considered bundled or incidental. Not eligible for separate payment. Always bundled into a related service.
CARC:	97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
RARC:	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.

B. Medicare Advantage lines of business

CPT codes 99100 – 99140 are status B codes and are not eligible for separate reimbursement.

C. Medicaid lines of business

CPT codes 99100 – 99140 are status B codes and are not eligible for separate reimbursement.

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation		Definition
AMA	=	American Medical Association
CARC	=	Claim Adjustment Reason Code
CCI	=	Correct Coding Initiative (see "NCCI")
CMS	=	Centers for Medicare and Medicaid Services
CPT	=	Current Procedural Terminology
CRNA	=	Certified Registered Nurse Anesthetist
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
EX	=	Explanation Code
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	=	Health Insurance Portability and Accountability Act
MS DRG	=	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	=	National Correct Coding Initiative (aka "CCI")
NHIC	=	National Heritage Insurance Corporation (NHIC)
RARC	=	Remittance Advice Remark Code
RPM	=	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
RVU	=	Relative Value Unit
UB	=	Uniform Bill

Procedure codes (CPT & HCPCS):

Code	Code Description
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)

Code	Code Description
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)

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

CPT Assistant:
"Question: *What are "qualifying circumstances for anesthesia," and when are they reported?*
Answer: Codes 99100-99140 are add-on codes that include a list of important qualifying circumstances that significantly affect the character of the anesthesia service provided. These circumstances would be reported as additional procedure numbers qualifying an anesthesia procedure or service. More than one code in the section may be selected, if applicable. Codes 99100-99140 are listed in the Anesthesia guidelines in the CPT codebook." (*AMA*[2])

Medicare Physician Fee Schedule:
Qualifying circumstances CPT codes 99100 – 99140 are assigned a status indicator of "B" (bundled code) on the CMS Physician Fee Schedule and are not eligible for separate reimbursement under Medicare guidelines. Per CMS, the value for these qualifying circumstances has already been included in the RVUs for the primary anesthesia procedure codes.

Cross References

A. "Modifier 47 - Anesthesia By Surgeon." Moda Health Reimbursement Policy Manual, RPM031.

B. "Anesthesia Physical Status Modifiers (P1 - P6)." Moda Health Reimbursement Policy Manual, RPM032.

C. "Moderate (Conscious) Sedation." Moda Health Reimbursement Policy Manual, RPM048.

References & Resources

1. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 2 Anesthesia Services.

2. American Medical Association. "Anesthesia Services Codes 00100-01999 FAQs." *CPT Assistant.* April 2008: 3-4.

3. NHIC, Corp. *Anesthesia Billing Guide.* NHIC, Corp. A CMS Intermediary J14 A/B. April 2013: 18.

4. CMS. Medicare Physician Fee Schedule Database.

Background Information

Anesthesia is the administration of a drug or anesthetic agent by an anesthesiologist or Certified Registered Nurse Anesthetist (CRNA) for medical or surgical purposes to relieve pain and/or induce partial or total loss of sensation and/or consciousness during a procedure. A variety of levels of anesthesia exist, ranging from local through general anesthesia. "As physicians, anesthesiologists are responsible for administering anesthesia to relieve pain and for managing vital life functions during surgery." [4]

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
7/13/2022	Formatting/Update: Change to new header. Acronym table: 5 entries added. Policy History section: Added. Entries prior to 2022 omitted (in archive storage).
8/14/2013	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
1/1/2000	Original Effective Date (with or without formal documentation). Policy based on CMS status B indicators on the Physician Fee Schedule.