 JOHNS HOPKINS MEDICINE JOHNS HOPKINS HEALTHCARE	JOHNS HOPKINS HEALTHCARE	Policy Number: RPC.007 Effective Date: 1/1/09 Revision Date: 10/1/2016
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ACTION

- New Policy
- Repealed Policy Date: _____
- Superseded Policy Number: _____

The most current version of the reimbursement policies can be found on www.jhhc.com.


These policies serve as a guide to assist you in accurate claim submissions and to outline the basis for reimbursement if the service is covered by a member’s Johns Hopkins HealthCare (JHHC) benefit plan. The determination that a service, procedure, item, etc. is covered under a member’s benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis as well as to the member’s state of residence. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services must be billed with ICD-10 codes, CPT codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating providers and facilities.

If appropriate coding/billing guidelines or current Reimbursement Policies are not followed, Johns Hopkins HealthCare (JHHC) may:

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

JHHC reimbursement policies are developed based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in provider or state contracts, or state, federal or CMS contracts and/or requirements. 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 variations.

JHHC reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy on www.jhhc.com.

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POLICY


I. GENERAL ANESTHESIA

- Anesthesia reimbursement is calculated using specific base units and time units. Base units 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 visits, administration of fluids/blood incidental to anesthesia care, and routine monitoring procedures. Time units are added to the base units to obtain total anesthesia units for the operative session
- Anesthesia time begins when the anesthesiologist or certified registered nurse anesthetist personally begins to prepare the patient for anesthesia care in the operating room or in an equivalent area. Anesthesia time ends when the anesthesiologist / 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. Documentation of anesthesia care start and stop times must be clearly reflected on the anesthesia record.
- Benefits **are provided** for anesthesia services only when rendered by an anesthesiologist or anesthetist/CRNA.
- Additional benefits **are not provided** for anesthesia services rendered by the operating surgeon, as they are considered included in the surgical allowance.
- Anesthesia services provided by CRNA under the medical direction of Anesthesiologists must be submitted with the following concurrency modifiers: QY, QX, and QK. For services provided by CRNA without medical direction, the claims must be submitted using QZ modifier.

Services Included In Base Unit Values:

Additional benefits **are not** provided for the following services, as they are considered included in the base anesthesia unit values:

- preoperative consultation/discussion of anesthesia plan and additional tests if needed to assess the anesthetic risk, including preoperative evaluation done in the staging area
- preoperative medication and/or medication orders
- administration of suitable anesthetic agents for the regional/anatomical site of surgery and any “preparation” of the patient
- intubation and/or placement of intravenous lines and appropriate monitoring (e.g., blood pressure, EKG, temperature, capnography, mass spectrometry, oximetry) to evaluate the vital functions of the patient, including blood pressure, pulse, tidal volume, and temperature
- initiation of mechanical ventilation during the anesthetic period maintenance of body fluid

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requirements, including blood replacement and prehydration performed in the preoperative staging area

- postoperative care/management of the patient in the PACU
- postoperative visit(s) by the anesthesiologist/anesthetist.
- standby anesthesia services

Anesthesia for Multiple Surgeries:

The total anesthesia benefit for multiple surgeries is based on the number of base units for the major or primary surgical procedure only and the total time indicated for all procedures. No additional benefits of base units are provided for secondary surgical procedures performed during the same operative setting.

Anesthesia When Surgery Is Canceled or Delayed:

- If the anesthesiologist performs the normal pre-anesthesia evaluation expecting to administer anesthesia, but the surgery is canceled prior to induction, then benefits **are provided** for the level of care rendered (i.e., inpatient, outpatient, or office evaluation and management visit)
- If the anesthesiologist performs the usual pre-anesthesia evaluation and induces anesthesia, but the surgery is canceled after the induction, then **benefits are provided** the surgical procedure base units /RVUs plus the actual time the anesthesiologist was in attendance.
- If the anesthesiologist performs the normal pre-anesthesia evaluation expecting to administer anesthesia, but the surgery is delayed (e.g., until later in the day), then additional benefits **are not provided**. This evaluation is considered integral to the complete anesthesia service.


Acupuncture as a Method of Anesthesia:

- When benefits are provided in the member's contract, acupuncture as a method of anesthesia for a covered surgical procedure when performed by a qualified, licensed physician other than the attending physician is covered.

Anesthesia Time:

For claims submitted on paper, Providers must bill the number of minutes and anesthesia start and stop times.

For claims billed electronically, Providers must submit the “MJ” qualifier, the number of minutes, and the anesthesia start and stop times in the NTE segment.

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Anesthesia Base:

This value is based on units assigned by CMS and are assigned to each CPT / ASA code.


CPT Codes:

Providers must bill Johns Hopkins HealthCare using the appropriate anesthesia CPT or ASA (American Society of Anesthesiology) codes.

Anesthesia time	Reimburses per unit (1 unit = 15 minutes) (rounds up to next unit if time is greater than an additional .5 minutes for US Family Health Plan claims, and rounds up to next unit if the time is 5.0 minutes or greater for EHP and Priority Partners claims.)
Anesthesia codes	Requires CPT or ASA anesthesia codes only.
Anesthesia base units	Base units are assigned to the anesthesia CPT and ASA
Line placements	Additional benefits are provided for placement of: <input type="checkbox"/> Swan-Ganz catheters <input type="checkbox"/> Arterial lines <input type="checkbox"/> CVP lines <input type="checkbox"/> Lines to superior or inferior vena cava
Qualifying Circumstances	Procedures codes 99100, 99116, 99135, and 99140 would not be reported alone but would be reported as additional procedure numbers qualifying an anesthesia procedure or service.
Anesthesia benefits when surgery is canceled prior to induction	Provider must bill the appropriate level evaluation and management visit for the setting.
Covered Physical Status Modifiers	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

II. OBSTETRICAL ANESTHESIA

Anesthesia services consist of the administration of an anesthetic agent to produce either a partial or

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complete loss of sensation. In obstetrics, anesthetic agents are most often administered via injections or continuous infusion into the subarachnoid, subdural, or epidural spaces of the spine, in order to produce circumscribed areas of loss of sensation. This type of anesthesia is often referred to as neuraxial analgesia.


A frequently used anesthesia technique used labor and delivery is continuous epidural analgesia. Customarily, an epidural catheter is placed during the first stage of labor. Pain is controlled during labor and childbirth by the continuous bathing of the lumbar nerve roots within the epidural space using an anesthetic agent administered through the indwelling catheter. Usually, the catheter remains in place through the delivery and may remain in place to achieve pain control after delivery

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. All OB anesthesia services must be submitted using units and time.

Reporting guidelines for various obstetrical anesthesia services for JHHC products and networks are as follows:

Non-elective deliveries associated with an episode of labor:

- Neuraxial analgesia/anesthesia for planned vaginal delivery (See ASA guide for appropriate reporting code 01967):
 1. Report up to 60 minutes of time for epidural catheter insertion and removal and delivery.[Note: These 60 minutes may be used at the discretion of the anesthesiologist.] If either the insertion/removal of the epidural catheter and/or the delivery, individually or combined, exceeds the 60 minute threshold, additional time may be reported provided the medical record documentation supports the need for additional time.
 2. Report 15 minutes of time for each hour patient is in labor. A notation must be made in the medical record, signed by the anesthesiologist or CRNA, which confirms that they visited the laboring patient during each hour of labor (a short progress note is acceptable for this notation).
 3. Report actual time, in minutes, for time spent with the patient for the management of complications or adverse events, provided that actual care time is fully documented in the medical record.

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4. **Do not report base units. Standard CMS base units are applied by our claims systems as with other non-obstetrical anesthesia procedures.**

- **NOTE:** this code is used for all vaginal deliveries and associated labor, and the labor portion of deliveries that are accomplished by Cesarean section.

Billing Guidelines for Code 01967:

Report total minutes and start and stop times. We will allow four (4) units for epidural catheter insertion and removal and delivery for the first 60 minutes reported. We will allow one unit for each additional 60 minutes of time reported where the patient is in labor. If the additional labor time reported is less than 60 minutes, we will round up to the next unit at 31 minutes. **For example, if 95 minutes of labor time are reported, we will allow one unit for the first 60 minutes and a second unit for the additional 35 minutes.**


- Unplanned Cesarean delivery following neuraxial labor analgesia/anesthesia (See ASA guide for appropriate reporting code 01968):
 - Report one unit per each 15 minutes increment.
 - Report as an add-on code along with code for neuraxial analgesia/anesthesia for planned vaginal delivery 01967.
 - Do not report base units. Standard CMS base units are applied by our claims systems as with other non-obstetrical anesthesia procedures.
 - This code is not reported in addition to code for unplanned Cesarean hysterectomy following neuraxial labor analgesia/anesthesia 01969.
- Unplanned Cesarean hysterectomy following neuraxial labor analgesia/anesthesia (See ASA guide for appropriate reporting code 01969):
 - Report one unit per each 15 minutes increment.
 - Report as an add-on code along with code for neuraxial analgesia/anesthesia for planned vaginal delivery 01967.
 - Do not report base units. Standard ASA base units are applied by our claims systems as with other non-obstetrical anesthesia procedures.

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- This code is not reported in addition to code for unplanned Cesarean delivery following neuraxial labor analgesia/anesthesia 01968.

Elective or non-elective deliveries and other obstetrical procedures **without** an episode of labor:

- Anesthesia for vaginal delivery only without associated labor (See ASA guide for appropriate reporting code 01960):
 - Report total minutes in operative time.
 - Do not report base units. Standard ASA base units are applied by our claims systems as with other non-obstetrical anesthesia procedures.
 - Do not report along with code for **neuraxial** analgesia/anesthesia for planned vaginal delivery 01967.
- Anesthesia for Cesarean delivery only (i.e., planned Cesarean delivery or unplanned Cesarean delivery without labor) (See ASA guide for appropriate reporting code 01961):
 - Report total minutes of operative time.
 - Do not report base units. Standard ASA base units are applied by our claim systems as with other non-obstetrical anesthesia procedures.
 - Do not report along with codes for neuraxial analgesia/anesthesia for planned vaginal delivery 01967 or unplanned Cesarean delivery following neuraxial labor analgesia/anesthesia 01968.
- Anesthesia for urgent hysterectomy following delivery (See ASA Guide for appropriate reporting code 01962):
 - Report total minutes of operative time.
 - Do not report base units. Standard ASA base units are applied by our claim systems as with other non-obstetrical anesthesia procedures.
 - Do not report along with code for neuraxial analgesia/anesthesia for planned vaginal deliver 01967 unplanned Cesarean delivery following neuraxial labor analgesia/anesthesia 01968 or unplanned Cesarean hysterectomy following neuraxial labor analgesia/anesthesia 01969.
- Anesthesia for Cesarean hysterectomy without labor anesthesia (See ASA* guide for appropriate reporting code 01963):

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- Report total minutes of operative time.
- Do not report base units. Standard ASA base units are applied by our claim systems as with other non-obstetrical anesthesia procedures.
- Do not report along with code for neuraxial analgesia/anesthesia for planned vaginal delivery 01967 unplanned Cesarean delivery following neuraxial labor analgesia/anesthesia 01968 or unplanned Cesarean hysterectomy following neuraxial labor analgesia/anesthesia 01969.

EXCLUSIONS


Services Not Included in Base Unit Values:

Additional benefits are provided for the following services, as they are not considered included in the base unit values and may be reported separately:

1. 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.
2. Physical Status modifiers are represented by the initial letter “P” followed by a single digit from 1 to 6 as defined in the following list. The following Physical Status Modifiers are covered:
 - 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

Additional units will not be recognized for the following physical status modifiers:

- P1 – A normal, healthy patient
- P2 – A patient with mild systemic disease
- P6 – A declared brain-dead patient whose organs are being removed for donor purposes

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3. Qualifying Circumstances: 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. This section includes a list of important qualifying circumstances that significantly affect 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.

- 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 addition to code for primary anesthesia procedure)
- 99135 Anesthesia complicated by utilization of controlled hypotension (List separately addition to code for primary anesthesia procedure)
- 99140 Anesthesia complicated by emergency conditions (specify) (List separately in code for primary anesthesia procedure)

CROSS REFERENCE (with other relevant policies, procedures, and/or workflows)

This policy has been developed through consideration of the following:

- CMS Guidelines
- AMPT Committee
- ASA Guidelines

APPROVALS

Steering Committee Approval Date: 8/11/2016

Last Review Dates: