Benefit Criteria for Anesthesia Services to Change for Texas Medicaid

Effective for dates of service on or after September 1, 2008, benefit criteria for anesthesia will change for Texas Medicaid. Click on the title to view the details.

Anesthesia is a benefit of Texas Medicaid and is payable to anesthesiologists and certified registered nurse anesthetists (CRNAs).

Anesthesia must be administered by an anesthesia practitioner. An anesthesia practitioner is defined as:

- An anesthesiologist.
- A CRNA.
- A qualified professional as identified by the Texas Medical Board (TMB), performing delegated services.

Anesthesia services provided in combination with most medical surgical procedures do not require prior authorization; however, some medical surgical procedures may require prior authorization. Anesthesia may be reimbursed if prior authorization for the surgical procedure was not obtained, but services provided by the facility, surgeon, and assistant surgeon will be denied.

For time-based anesthesia procedure codes, anesthesia practitioners must document interruptions in anesthesia time in the client’s medical record. Anesthesia time begins when the anesthesia practitioner begins to prepare the client for the induction of anesthesia in the operating room or the equivalent area and ends when the anesthesia practitioner is no longer in personal attendance (e.g., when the client may be safely placed under postoperative supervision).

The documented time must be the same in the records or claims of the anesthesiologist and other anesthesia practitioners who were medically directed by the anesthesiologist. One time unit is equal to 15 minutes of anesthesia. Providers must submit the total anesthesia time in minutes on the claim. The claims administrator will convert total minutes to time units.

To be reimbursed, providers of anesthesia services must include the following on submitted claims:

- Appropriate anesthesia procedure codes.
- Correct modifier combination.
- Exact amount of face-to-face time with the client.

Procedure codes 1-99100, 1-99116, 1-99135, and 1-99140 are not payable alone, but are payable when combined with the anesthesia service. Documentation supporting the medical necessity for use of the procedure codes must be available to state agencies upon request and is subject to retrospective review.

Medical Direction

Personal medical direction by an anesthesiologist of an anesthesia practitioner is a benefit of Texas Medicaid if the following criteria are met:

- No more than four anesthesia procedures are being performed concurrently.
Exception: Anesthesiologists may medically direct more than four anesthesia services or simultaneously supervise more than a combination of four CRNAs or other qualified professionals, as defined by the Texas Medical Board (TMB), under emergency circumstances only.

- The anesthesiologist is physically present in the operating suite.

Medical direction is a benefit of Texas Medicaid if the following criteria are met:

- The anesthesiologist performs a pre-anesthetic examination and evaluation.
- The anesthesiologist prescribes the anesthesia plan.
- The anesthesiologist personally participates in the critical portions of the anesthesia plan, including induction and emergence.
- The anesthesiologist ensures that a qualified professional can perform the procedures in the anesthesia plan that the anesthesiologist does not perform personally.
- The anesthesiologist monitors the course of anesthesia administration at frequent intervals.
- The anesthesiologist remains physically present and available for immediate diagnosis and treatment of emergencies.
- The anesthesiologist provides postanesthesia care.
- The anesthesiologist does not perform any other services (except as noted below) during the same time period. The anesthesiologist directing the administration of no more than four anesthesia procedures may provide the following without affecting the eligibility of the medical direction services:
  - Address an emergency of short duration in the immediate area.
  - Administer an epidural or caudal anesthetic to ease labor pain.
  - Provide periodic, rather than continuous, monitoring of an obstetrical patient.
  - Receive clients entering the operating suite for the next surgery.
  - Check or discharge clients in the recovery room.
  - Handle scheduling matters.

As noted above, an anesthesiologist may concurrently medically direct up to four anesthesia procedures. Concurrency is defined as the maximum number of procedures that the anesthesiologist is medically directing within the context of a single procedure and whether those other procedures overlap each other. Concurrency is not dependent on each of the cases involving a Medicaid client. For example, if three procedures are medically directed but only two involve Medicaid clients, the Medicaid claims should be billed as concurrent medical direction of three procedures.

The following information must be available to state agencies upon request and is subject to retrospective review:

- The name of each CRNA and other qualified professional that is concurrently medically directed or supervised and a description of the procedure that was performed must be documented and maintained on file.
• Signatures of the anesthesiologist, CRNAs, or other qualified professionals involved in administering anesthesia services must be documented in the client’s medical record.

Monitored Anesthesia Care

Monitored anesthesia care may include any of the following:

• Intraoperative monitoring by an anesthesiologist or qualified professional under the medical direction of an anesthesiologist.
• Monitoring of the client’s vital physiological signs in anticipation of the need for general anesthesia.
• Monitoring of the client’s development of an adverse physiological reaction to a surgical procedure.

Anesthesia Modifiers

Each anesthesia procedure code must be submitted with the appropriate anesthesia modifier combination whether billing as the sole provider or for the medical direction of CRNAs or other qualified professionals.

When an anesthesia service is billed without the appropriate reimbursement modifiers, or is billed with modifier combinations other than those listed in this article, the claim will be denied.

A procedure billed with a modifier indicating that the anesthesia was personally performed by an anesthesiologist (modifier AA) will be denied if another claim has been paid indicating the service was personally performed by, and paid to, a CRNA (modifier QZ) for the same client, date of service, and procedure code. The opposite is also true—anesthesia personally performed by a CRNA will be denied if a previous claim indicates the service was personally performed by, and paid to, an anesthesiologist for the same client, date of service, and procedure code. Denied claims may be appealed with supporting documentation of any unusual circumstances.

State-Defined Modifiers

Modifiers U1 (indicating one Medicaid claim) and U2 (indicating two Medicaid claims) are state-defined modifiers that must be billed by an anesthesiologist or CRNA.

Modifier U1, indicating that only one Medicaid claim will be submitted, cannot be billed by two providers for the same procedure, client, and date of service. Modifier U2, indicating that two Medicaid claims will be submitted, can only be billed by two providers for the same procedure, client, and date of service if one of the providers was medically directed by the other. Denied claims may be appealed with supporting documentation of any unusual circumstances.

Anesthesia providers must submit the U1 or U2 modifier with an appropriate pricing modifier when billing for anesthesia procedure codes.

Anesthesiologist Services

Modifiers AA and U1 must be submitted when an anesthesiologist has personally performed the anesthesia service.
Anesthesiologists may be reimbursed for medical direction of anesthesia practitioners by using one of the following modifier combinations:

<table>
<thead>
<tr>
<th>Modifier Combination Submitted by Anesthesiologist</th>
<th>When is it used?</th>
<th>Who will submit claims?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anesthesiologist Directing Non-CRNA Qualified Professionals</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>QY and U1</td>
<td>When directing one procedure provided by a non-CRNA qualified professional</td>
<td>Only the anesthesiologist</td>
</tr>
<tr>
<td>QK and U1</td>
<td>When directing two, three, or four concurrent procedures provided by non-CRNA qualified professionals</td>
<td>Only the anesthesiologist</td>
</tr>
<tr>
<td>AD and U1</td>
<td>When directing five or more concurrent procedures provided by non-CRNA qualified professionals. Used in emergency circumstances only and limited to 6 units (90 minutes) per case for each occurrence requiring five or more concurrent procedures</td>
<td>Only the anesthesiologist</td>
</tr>
<tr>
<td><strong>Anesthesiologist Directing CRNAs</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>QY and U2</td>
<td>When directing one procedure provided by a CRNA</td>
<td>Both the anesthesiologist and CRNA</td>
</tr>
<tr>
<td>QK and U2</td>
<td>When directing two, three, or four concurrent procedures involving CRNA(s)</td>
<td>Both the anesthesiologist and CRNA</td>
</tr>
<tr>
<td>AD and U2</td>
<td>When directing five or more concurrent procedures involving CRNA(s). Used in emergency circumstances only and limited to 6 units (90 minutes) per case for each occurrence requiring five or more concurrent procedures</td>
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</tbody>
</table>

**CRNA Services**

Modifiers QZ and U1 must be submitted when a CRNA has personally performed the anesthesia services, is not medically directed by the anesthesiologist, and is directed by the surgeon.
Modifiers QX and U2 must be submitted by a CRNA who provided services under the medical direction of an anesthesiologist.

**Monitored Anesthesia Care**

Anesthesiologists and CRNAs may use modifier QS to report monitored anesthesia care.

The QS modifier is an informational modifier, and must be billed with any combination of pricing modifiers for reimbursement.

**Dental General Anesthesia**

Modifier EP must be used to indicate that the anesthesia was performed with dental services. Supporting documentation for the use of general anesthesia (procedure code 7-00170) with the EP modifier, while rendering treatment (to include the dental service fee, the anesthesia fee, and the facility fee), must be retained in the client’s medical record regardless of prior authorization, and must reflect compliance with the “Criteria for Dental Therapy Under General Anesthesia” (22 point threshold) and the “Criteria for Dental Therapy Under General Anesthesia, Attachment 1” forms.

Prior authorization is required for the use of general anesthesia (procedure code 7-00170) with the EP modifier, while rendering treatment (to include the dental service fee, the anesthesia fee, and the facility fee), regardless of place of service, for clients who do not meet the requirements of the “Criteria for Dental Therapy Under General Anesthesia” (22 point threshold) and the “Criteria for Dental Therapy Under General Anesthesia, Attachment 1” forms. Supporting documentation, including the appropriate narrative, must be submitted to TMHP for prior authorization.

In those areas of the state with Medicaid Managed Care, precertification or approval is required from the client’s health maintenance organization (HMO) for anesthesia and facility charges. It is the dental provider’s responsibility to obtain precertification from the client’s HMO or managed care plan for facility and general anesthesia services.

A random, statistically valid, retrospective review of one to two percent of all anesthesiologist’s dental records will be conducted to determine if documentation and compliance with all Texas Medicaid policies are reflected in the provider’s records.

The completed Criteria for Dental Therapy Under General Anesthesia form, the appropriate narrative, and all supporting documentation must be included in the client’s dental record. The client’s dental record must be available for review by representatives of the Department of State Health Services (DSHS) or its designee and/or the Health and Human Services Commission (HHSC) or its designee. The dental provider is required to maintain the following documentation in the client’s dental record:

- The medical evaluation justifying the need for anesthesia.
- Description of relevant behavior and reference scale.
- Other relevant narrative justifying the need for general anesthesia.
- Client’s demographics, including date of birth.
- Relevant dental and medical history.
- Dental radiographs, intraoral/perioral photography and/or diagram of dental pathology.
• Proposed Dental Plan of Care.
• Consent signed by parent/guardian giving permission for the proposed dental treatment and acknowledging that the reason for the use of IV sedation or general anesthesia for dental care has been explained.
• Dentist's attestation statement and signature, which is on the bottom of the Criteria for Dental Therapy Under General Anesthesia form or included in the record as a stand-alone form.

Dental general anesthesia is limited to once every six months per client per provider. Medically necessary services exceeding this limitation require prior authorization. Dental rehabilitation and restoration services requiring general anesthesia are performed in an outpatient facility. Hospital and outpatient facility admissions are subject to medical necessity review. Services will not be monitored for clients 20 years of age and younger.

Reimbursement

The anesthesiologist's reimbursement for medical direction of CRNAs and non-CRNA qualified professionals is 100 percent of the maximum allowable fee. If multiple CRNAs or anesthesiologists are providing anesthesia services for a client, only one CRNA and one anesthesiologist may be reimbursed.

Time-Based Fees

Reimbursement of time-based anesthesia services is derived from the following steps:

1. Divide the total anesthesia time in minutes (the time of all procedures performed, directed or supervised) by 15.
2. Add the relative value units (RVUs) for the procedure performed (use the procedure with the highest RVUs when multiple procedures are performed at the same time).
3. Multiply this sum by the appropriate conversion factor.

The formula for this methodology is as follows: 
\[(\text{Minutes}/15) + \text{RVUs} \times \text{Conversion Factor} = \text{Anesthesia Reimbursement}.\]