

**NOTE:** The attachment to MA Bulletin 31-04-06, 32-04-01 is replaced by the attachment to MA Bulletin 31-04-07, 32-04-02.

	<b>MEDICAL ASSISTANCE BULLETIN COMMONWEALTH OF PENNSYLVANIA * DEPARTMENT OF PUBLIC WELFARE</b>		
	<b>NUMBER:</b> 31-04-06 32-04-01	<b>ISSUE DATE:</b> June 22, 2004	<b>EFFECTIVE DATE:</b> July 1, 2004
<b>SUBJECT:</b> Procedure Codes for Anesthesia Services	<b>BY:</b>  <b>David S. Feinberg Deputy Secretary for Medical Assistance Programs</b>		

**PURPOSE:**

The purpose of this bulletin is to announce changes to the Department's payment methodology and procedure codes for anesthesia services. The addition of specific procedure codes for anesthesia services will more accurately reflect the manner in which anesthesia care is delivered. Additionally, the changes will bring the Medical Assistance (MA) procedure coding system into compliance with Title II of the Health Insurance Portability and Accountability Act (HIPAA) and accompanying regulations, which require that the MA Program adopt national code sets for all procedures. See 42 U.S.C. §§ 1320d-1320d-8; 45 C.F.R. §§ 160.101-.312, 162.1000-.1011. These procedure codes will be effective for anesthesia services provided on or after July 1, 2004.

**SCOPE:**

This bulletin applies to all providers of anesthesia services enrolled in the MA Program Fee-for-Service delivery system. Providers of anesthesia services enrolled in the MA Program who receive payment from managed care organizations (MCOs) under contract with the Department are instructed to contact their individual MCOs for information on the impact of this Bulletin on MCO specific billing and claims processing.

**BACKGROUND/DISCUSSION:**

The primary goal of HIPAA is to make it easier for people to maintain health insurance and to help the industry control administrative costs by standardizing health care transactions for all health plans, clearinghouses and providers who submit claims electronically.

HIPAA is divided into five Titles or Sections. Title II is called Administrative Simplification. The goal of Administrative Simplification is to reduce health care administrative costs and promote continuity of care by facilitating electronic data interchange (EDI). One of the standards established by HIPAA is national transaction and code sets. The procedure code sets that have been accepted by HIPAA are as follows:

- International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)-Diagnosis (all services) and inpatient procedures;
- National Drug Codes (NDC)-Drugs, biologicals;
- Current Dental Terminology, third edition (CDT-3)-Dental Services;
- Current Procedural Terminology, fourth revision (CPT-4)-Physician and other services;
- Healthcare Common Procedure Coding System (HCPCS) Level II- Medical equipment, injectible drugs, transportation services, and other services not found in CPT-4; and
- CMS Health Care Claim Adjustment Reason Codes and Remittance Advice Remarks Codes.

## **PROCEDURE:**

In order to comply with Title II of HIPAA, the Department conducted research regarding Medicare's payment methodology in regard to anesthesia services and as a result the Department has developed an anesthesia payment methodology similar to many of Medicare's payment policies. Effective July 1, 2004, the following payment methodology will be utilized for various anesthesia services:

1. **Conversion Factor:** For the purposes of payment, the Department will utilize 100% of the Medicare Pennsylvania-specific 2004 conversion factor, which is \$17.04, as well as the base units assigned by Medicare. The pricing formula is as follows: (base unit assigned to each procedure code X conversion factor) + (conversion factor X time units).
2. **Reporting Time:** For purposes of reporting the amount of time the service was rendered, the Department will utilize the Medicare definition of anesthesia time. Anesthesia time involves the continuous actual presence of the anesthesiologist and starts when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room or equivalent area and ends when the anesthesiologist is no longer in personal attendance, i.e., when the patient may be safely placed under postoperative supervision. Providers must document in the patient's record the actual time that the administration of anesthesia began and the time at which the patient no longer required the services of the anesthesiologist. Providers will be responsible to report the minutes they rendered service in accordance with the definition of anesthesia time. When reporting the minutes, providers should report in whole minutes. Fractions of a minute should be rounded to whole minutes (30 seconds or greater: round up, less than 30 seconds: round down). For billing purposes, the number of minutes of anesthesia time will be placed in space 24G on the CMS 1500 for providers who bill in a paper format. Upon retrospective review the minutes billed must match the minutes in the record. The Department will convert the reported minutes to units. One unit equals fifteen (15) minutes. The units will be rounded to the nearest tenth (5 or greater: round up, below 5: round down).
3. **Obstetrical Anesthesia:** For the following specified obstetrical anesthesia codes: 01960, 01961, 01962, 01963 and 01967, the Department will use the same pricing formula but will adjust the Medicare base units by adding 4 units to the Medicare base units, which will result in the payment of an additional hour unit.
4. **Multiple Surgeries:** In accordance with existing Departmental policy set forth at 1150.52(c), "When two or more surgical procedures are performed and anesthesia is provided by the same anesthesiologist during the same period of hospitalization, the anesthesiologist will be reimbursed at 100% for the highest allowable payment for one procedure and 25% for the second highest paying procedure, with no payment for additional procedures."

When two or more surgical procedures are performed during the same surgical event, and anesthesia is provided by the same anesthesiologist, the anesthesiologist should bill for the highest billable anesthesia procedure code. All anesthesia time must be allotted to that single anesthesia procedure code. No payment will be made for additional anesthesia procedures provided during that surgical event.

5. **Surgery Cancellation:** In the event that a surgery is cancelled, the anesthesiologist must bill for the actual number of

minutes spent with the patient in accordance with the definition of anesthesia time.

The 2004 Anesthesia Procedure Codes Chart is attached and includes anesthesia procedure codes being added to the MA Program Fee Schedule to bring the MA procedure coding system into compliance with HIPAA requirements. These procedure codes will be effective for anesthesia services provided on or after July 1, 2004. Services rendered on June 30, 2004 or prior must be billed using the previous medical or surgical procedure code with the AA modifier. Effective with services rendered July 1, 2004 and after, the AA modifier is no longer necessary when billing the anesthesia procedure codes listed on the attached 2004 Anesthesia Procedure Codes Chart.

Existing Departmental regulations set forth at 55 Pa.Code 1101.51(e)(1) related to record keeping requirements and onsite access; 1101.67 related to prior authorization; and 1150.52 related to anesthesia services, remain in effect and can be accessed at <http://www.pacode.com/secure/data/055/055toc.html>.

Detailed billing instructions are included in the PROMISe™ Billing Guide, Companion Guide, and Bridge Guide, which are available on the OMAP web site at <http://www.dpw.state.pa.us/omap/promise/omappromise.asp>.

**ATTACHMENT:**

**2004 Anesthesia Procedure Codes Chart**

**COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:**

**The Appropriate Toll Free Number for Your Provider Type**

Visit the Office of Medical Assistance Programs website at [www.dpw.state.pa.us/omap](http://www.dpw.state.pa.us/omap)