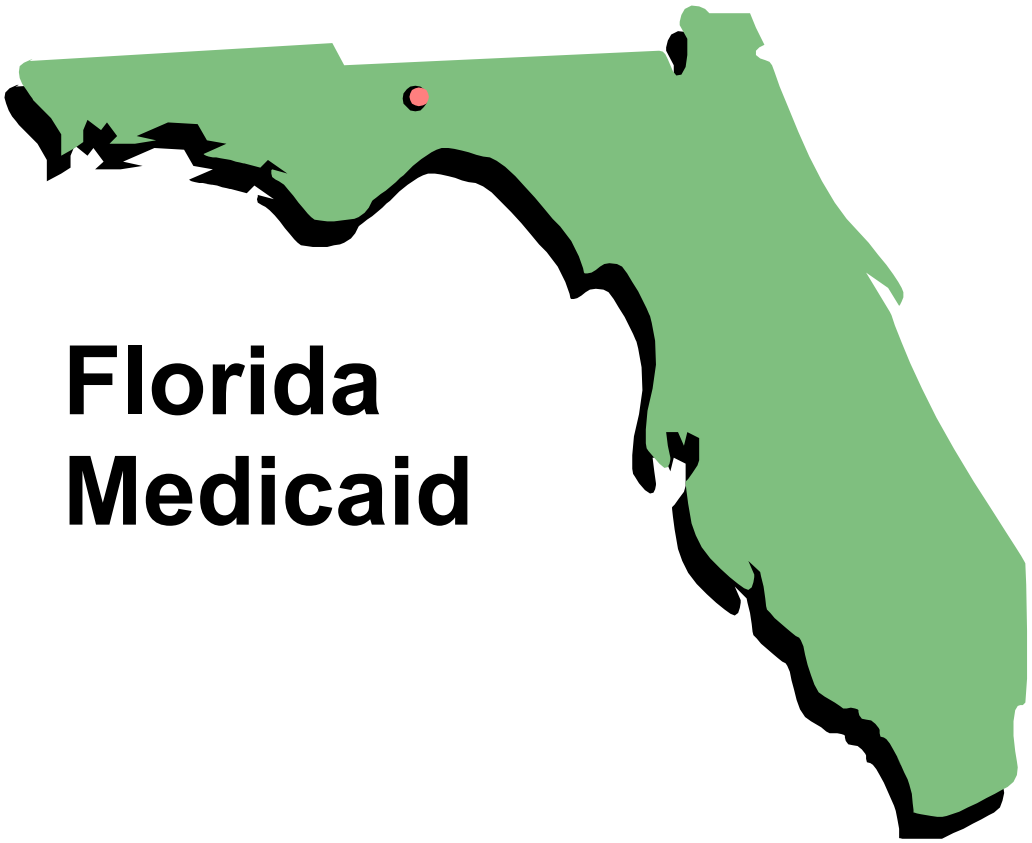

Florida Medicaid

Anesthesia Services Coverage Policy

Agency for Health Care Administration

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Table of Contents

1.0 Introduction

1.1 Description

Florida Medicaid anesthesia services include the management of general anesthesia to render a recipient insensible to pain and emotional stress during medical procedures.

1.1.1 Florida Medicaid Policies

This policy is intended for use by providers that render anesthesia services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid's general policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency for Health Care Administration's (AHCA) Web site at http://ahca.myflorida.com/Medicaid/review/index.shtml.

1.1.2 Statewide Medicaid Managed Care Plans

This Florida Medicaid policy provides the minimum service requirements for all providers of anesthesia services. This includes providers who contract with Florida Medicaid managed care plans (i.e., provider service networks and health maintenance organizations). Providers must comply with the service coverage requirements outlined in this policy, unless otherwise specified in AHCA's contract with the Florida Medicaid managed care plan. The provision of services to recipients in a Florida Medicaid managed care plan must not be subject to more stringent service coverage limits than specified in Florida Medicaid policies.

1.2 Legal Authority

Anesthesia services are authorized by the following:

- Title XIX of the Social Security Act (SSA)
- Title 42, Code of Federal Regulations (CFR), Parts 440 and 441
- Section 409.905 Florida Statutes (F.S.)
- Rule 59G-4.022, F.A.C.

1.3 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid definitions policy.

1.3.1 Claim Reimbursement Policy

A policy document that provides instructions on how to bill for services.

1.3.2 Coverage and Limitations Handbook or Coverage Policy

A policy document that contains coverage information about a Florida Medicaid service.

1.3.3 General Policies

A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1 containing information that applies to all providers (unless otherwise specified) rendering services to recipients.

1.3.4 Medically Necessary/Medical Necessity

As defined in Rule 59G-1.010, F.A.C.

1.3.5 Provider

The term used to describe any entity, facility, person, or group that has been approved for enrollment or registered with Florida Medicaid.

1.3.6 Recipient

For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

2.0 Eligible Recipient

2.1 General Criteria

An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy.

Provider(s) must verify each recipient's eligibility each time a service is rendered.

2.2 Who Can Receive

Florida Medicaid recipients requiring medically necessary anesthesia services. Some services may be subject to additional coverage criteria as specified in section 4.0.

2.3 Coinsurance, Copayment, or Deductible

There is no coinsurance, copayment, or deductible requirement for this service

3.0 Eligible Provider

3.1 General Criteria

Providers must be at least one of the following to be reimbursed for services rendered to eligible recipients:

- Enrolled directly with Florida Medicaid if providing services through a fee-for-service delivery system
- Enrolled directly or registered with Florida Medicaid if providing services through a managed care plan

3.2 Who Can Provide

Practitioners licensed within their scope of practice to perform this service.

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid reimburses for services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

4.2 Specific Criteria

Florida Medicaid reimburses for anesthesia as an adjunct to the following services in accordance with the American Medical Association Current Procedural Terminology and the applicable Florida Medicaid fee schedule(s):

- Surgical procedures
- Medical procedures
- Obstetrical procedures
- Dental procedures

4.2.1 Epidural Anesthesia

Florida Medicaid reimburses for up to 360 minutes of epidural anesthesia for a vaginal delivery or a cesarean delivery.

4.2.2 Monitored Anesthesia Care (MAC)

Florida Medicaid reimburses for MAC, when billed with the anesthesia codes, when providers anticipate a recipient may either:

- Require general anesthesia
- Develop an adverse physiological reaction during the surgical procedure

4.3 Early and Periodic Screening, Diagnosis, and Treatment

As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's authorization requirements policy.

5.0 Exclusion

5.1 General Non-Covered Criteria

Services related to this policy are not reimbursed when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider's service

5.2 Specific Non-Covered Criteria

Florida Medicaid does not reimburse for the following:

- More than 360 minutes of epidural anesthesia
- Services for medical procedures that are not Florida Medicaid compensable
- Services that are not listed on the fee schedule
- Telephone communications with recipients, their representatives, caregivers, and other providers, except for services rendered in accordance with the Florida Medicaid telemedicine policy

6.0 Documentation

6.1 General Criteria

For information on general documentation requirements, please refer to Florida Medicaid's recordkeeping and documentation policy.

6.2 Specific Criteria

There is no coverage-specific documentation requirement for this service.

7.0 Authorization

7.1 General Criteria

The authorization information described below is applicable to the fee-for-service delivery system, unless otherwise specified. For more information on general authorization requirements, please refer to Florida Medicaid's authorization requirements policy.

7.2 Specific Criteria

Providers must obtain authorization for anesthesia services from the quality improvement organization when indicated on the applicable Florida Medicaid fee schedule(s).

8.0 Reimbursement

8.1 General Criteria

The reimbursement information below is applicable to the fee-for-service delivery system, unless otherwise specified.

8.2 Claim Type

Professional (837P/CMS-1500)

8.3 Billing Code, Modifier, and Billing Unit

Providers must report the most current and appropriate billing code(s), modifier(s), and billing unit(s) for the service rendered, as incorporated by reference in Rule 59G-4.002, F.A.C.

8.3.1 Billing Code

Providers must include the appropriate code based on the major procedure performed on the claim form.

Providers must use procedure code 01967 for continuous epidural analgesia during labor and vaginal delivery on the claim form.

Providers must use procedure code 01967 with the service time, and 01968 with one minute of service time if the service progressed to a caesarian delivery.

8.3.2 Modifier

Providers must include the following modifiers, as appropriate, on the claim form:

- 78 Unplanned return to the operating room, related procedure
- QK Physician supervision of anesthesia
- QS MAC

8.3.3 Billing Unit

Providers must include the number of units on the claim form based on the total anesthesia service time. Any portion of a 15-minute increment equals one unit.

The calculation for reimbursement of anesthesia services is:
Anesthesia Base Rate + (time/15 x $14.50) = maximum reimbursement.

- Time is reported in total minutes, not units. During claim processing, the total time is divided by 15-minute increments. The resulting number will always round down to the nearest whole unit.

Example: If total time is 53 minutes 53/15=3.53, which will be rounded down to 3 units.

8.4 Diagnosis Code

Providers must report the most current and appropriate diagnosis code to the highest level of specificity that supports medical necessity, as appropriate for this service.

8.5 Rate

For a schedule of rates, as incorporated by reference in Rule 59G-4.002, F.A.C., visit AHCA's Web site at http://ahca.myflorida.com/Medicaid/review/index.shtml.

8.5.1 Payment Calculation

Florida Medicaid calculates reimbursement for services in accordance with 42 CFR 414.46.

8.5.2 Global Surgery Package

Florida Medicaid reimbursement includes all necessary services normally furnished by a surgeon before, during, and after a procedure in accordance with the Centers for Medicare and Medicaid Services' (CMS) global surgery period specifications.

For more information, see the CMS Web site at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/GlobalISurgery-ICN907166.pdf.

8.5.3 Enhanced Reimbursement Rate

Florida Medicaid reimburses pediatric surgery and urological specialty enrolled providers at the enhanced rate when indicated on the fee schedule.