

# Parkview Health Plan Services 2011

## Signature Care Anesthesia Claim Submission Guidelines

Parkview Health Plan Services (HPS) uses recommendations set by the American Society of Anesthesiologists and Medicare's Correct Coding Initiatives as a benchmark in establishing the guidelines set forth below. HPS is the reprinter for multiple payers in the Signature Care network. For anesthesia claims submitted to **Signature Care PPO**, the payer determines if the services are covered, not HPS. For questions concerning benefits for anesthesia related services, please call the payer at the number on the member's identification card. HPS is the payer for Parkview Health employees who enroll in Signature Care. The general anesthesia guidelines below apply to all claims reprinted or processed through HPS **effective 1/1/09**.

### Time Unit Calculation

Time increments of 15 minutes are converted to equal 1 unit in the calculation of anesthesia reimbursement. The current HPS anesthesia conversion factor is multiplied by the number of time increments billed. Anything in excess of a full 15-minute increment will be rounded up to the nearest tenth.

Example: 80 Minutes of Code 01630 = 5 Base Units + 5.4 Units of Time

Labor epidural "run time" is calculated at 1 unit per hour as endorsed and published in the ASA Relative Value Guide of 2010.

### Claim Submission Guidelines

Total Minutes only should be reported in box 24G on the HCFA. HPS claim systems has base units loaded for an accurate reimbursement calculations on Signature Care claims.

Example:	ABC Anesthesia
Service rendered:	Insertion of ear tubes
Time:	30 minutes                      Base Units: 4 units
Procedure Code:	00126 (Anesthesia for procedures on external, middle and inner ear including biopsy; tympanotomy)

In example above, 30 should be reported in box 24G on HCFA. Start and stop times should be present if submitting claims on paper.

### Submit Anesthesia codes only

#### Claim type

Claim type is an indicator to ensure correct payment of your claim. Anesthesia services should be submitted with a claim **Type 7 in box 24C** of the HCFA. Claims submitted with type of service 7 are calculated at the current anesthesia conversion factor. Only one line with type of service 7 is eligible for reimbursement per claim.

#### Modifiers

The AA modifier is informational only for Signature Care repricing/processing purposes. Any modifier reported that would affect reimbursement should be reported in the first position following the anesthesia code. Examples are:

- Physical status modifiers (P3 – P5)
- Medical direction modifiers for CRNA's (QY, QK, or QX)

- If physical and medical direction modifiers are both billed at the same time, please use the medical direction modifier in the first position.

### **CRNA Guidelines**

Certified Registered Nurse Anesthetist's claims should be submitted on a HCFA claim form with the CRNA's name in box 31, whether working alone or when being medically directed by an MD.

CRNA services with medical direction from a physician should be reported using modifier QX. Reimbursement is reduced 50% in accordance with Medicare guidelines.

MD's billing for medical direction of CRNA's should report their services on a separate claim appended with a QY or QK modifier as appropriate. Total minutes should be reported in box 24G of the HCFA and the physician's name in box 31. Reimbursement is reduced 50% in accordance with Medicare guidelines.

### **Qualifying circumstances**

Services incidental to the anesthesia service should be reported with a **Type 2 in box 24C** on the HCFA claim form. Units on type 2 services should indicate the number of procedures; not the time involved. Claim lines submitted with a type of service 2 are calculated at the current HPS fee schedule.

### **Multiple Surgeries**

If multiple surgeries are performed, anesthesia providers should bill the primary anesthesia procedure code and the total time in minutes for the primary procedure plus secondary procedures in box 24G.

### **Labor Epidural:**

Labor epidural services will be calculated by allowing 2 units for placement of the catheter, plus base, plus run time. For the purpose of repricing, run time is calculated at 1 unit per hour. The 2 units for placement and the base units are pre-loaded in the HPS system.

**Report total minutes of run time in box 24g on the anesthesia service line. (The HPS repricing system will convert total minutes into run time units.)**

Example: 01967 Report run time of 6 hours in Box 24G in this way:

**(6 x 60 minutes = 360 minutes)**

360
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### **Evaluation and Management:**

**History and Physicals** prior to surgery are not eligible for reimbursement, unless it is a significant and separately identifiable evaluation and management service, or the surgery is cancelled based on the findings of the H & P. In those instances, the service is reported by appending the E/M code with a -25 modifier.

**Consultation and Same Day Surgery:** Typically, this is not a separate billable service, however, HPS will consider on a case-by-case basis with appropriate documentation.

**Additional Procedures:**

HPS will recognize and consider the following anesthesia-related procedures for repricing at the current HPS fee schedule. This listing is not all-inclusive, does not guarantee payment, and may be subject to change.

Code	Description	Code	Description
36620	Arterial catheterization	99100	Extreme age
36555 to 36571	Placement of central venous catheter	99116	Total body hypothermia
93503	Swan Ganz	99135	Controlled hypotension
93313	Placement of TEE	99140	Emergency conditions

HPS will not recognize/reimburse for the following anesthesia-related services. Charges cannot be passed on to the member as patient responsibility.

Code	Description
	Field Avoidance
01999	Unlisted Anesthesia procedure.
	Positioning
	Bonus time
31575, 31622, 91105	Intubations (included in anesthesia service)

**Pain Management**

Pain management procedures will be processed/repriced at the current fee schedule if covered by the members' benefit plan. Pain management services **may require a separate authorization** when performed independently of other services in a physicians' office or ambulatory surgery center, or outpatient hospital setting. Authorizations must be obtained prior to treatment.

Post-surgical pain management and subsequent days post-surgery in an inpatient setting may be covered under the surgery authorization obtained by the surgeon. Please check with the member's Payer for authorization requirements.

*The above information does not constitute a guarantee of payment. Please verify eligibility and benefits from the appropriate payer. Guidelines for other networks contracted by HPS may vary. For questions concerning codes not appearing on this document, please contact HPS Provider Service Dept at (800) 666-4449, extension 39080.*