



State of New Mexico  
Medical Assistance Program Manual  
**Supplement**



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TO: ALL PROVIDERS OF ANESTHESIA SERVICES  
FROM: JULIE WEINBERG, ACTING DIRECTOR, MEDICAL ASSISTANCE DIVISION  
BY: ROSEMARY B. MEDRANO, BENEFITS BUREAU  
SUBJECT: ANESTHESIA SERVICES REGULATION

The New Mexico Human Services Register, Vol. 33 No. 41, dated September 30, 2010, contained final rules related to anesthesia services. The final rule indicates an implementation date of November 1, 2010.

The Human Services Department is now intending to implement the anesthesia rule on December 1, 2010. Effective for dates of service December 1, 2010, providers will be required to submit claims for anesthesia services with anesthesia CPT procedure codes. For dates of service prior to December 1, 2010, providers will continue to use the surgical CPT procedure codes. This will also apply to claim adjustments for dates of service prior to December 1, 2010.

The following information highlights some of the changes related to reimbursement and billing that will go into effect beginning with dates of service December 1, 2010.

**Changes to Billing and Reimbursement of Anesthesia Services:**

- Conversion factor: The anesthesia conversion factor will remain at \$18.43. This rate applies to anesthesia providers that are not medically directing or who are not medically directed. Reimbursement to the physician who is medically directing and to the CRNA and/or AA who is medically directed will be at 50% of the allowed amount.

- Modifiers:

Anesthesiologists will be limited to the following modifiers. Certified Registered Nurse Anesthetists (CRNA's) and anesthesiology assistants (AA's) will not be allowed to use these modifiers.

| MODIFIER | DESCRIPTION  |
|----------|--|
| AA       | Anesthesia services personally performed by the anesthesiologist         |
| QY       | Medical direction of one CRNA by an anesthesiologist                     |
| QK       | Medical direction of two, three or four concurrent anesthesia procedures |
| AD       | Supervision, more than four procedures                                   |

Certified Registered Nurse Anesthetists (CRNA's) and anesthesiology assistants (AA's) will be required to use the following modifiers.

| MODIFIER | DESCRIPTION  |
|----------|--|
| QX       | CRNA service: with medical direction by a physician    |
| QZ       | CRNA service: without medical direction by a physician |

The Monitored Anesthesia Care (MAC) modifier can be billed by a physician, CRNA or AA and must be used with the anesthesia service CPT procedure provided if MAC is delivered. This modifier will follow the modifier that indicates who provided the service (example: AA QS). No additional payment is made when this modifier is used.

| MODIFIER | DESCRIPTION                        |
|----------|------------------------------------|
| QS       | Monitored Anesthesia Care services |

- Calculating anesthesia time: Anesthesia time begins when the anesthesiologist starts to prepare the patient for the procedure. Normally, this service takes place in the operating room, but in some cases, preparation may begin in another location (i.e., holding area). Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service. In counting anesthesia time, the anesthesia practitioner can add blocks of time around an interruption in anesthesia time as long as the anesthesia practitioner is furnishing continuous anesthesia care within the time periods around the interruption.

Base units must not be added to the billed units of service, these units will be added to the total allowed units of service in claims processing. An anesthesia provider who is billing on the CMS 1500 claim form or its equivalent, must bill time units. Time units are calculated as one (1) unit for each fifteen (15) minutes of anesthesia time. If billing electronically the provider may submit units of time or total minutes of time. If billing total minutes of time, the provider must enter a line unit indicator of "MJ" on the 837 transaction.

Time units are to be calculated by dividing the total time by 15. Providers are to round to the next tenth and not the next whole number.

**Example:**

$$95 \text{ MINUTES} \div 15 = 6.33 = 6.3$$

$$79 \text{ MINUTES} \div 15 = 5.26 = 5.3$$

- **Medical Direction:** Prior to December 1, 2010, medical direction by a physician of a Certified Registered Nurse Anesthetist (CRNA) or anesthesiology assistant (AA) was calculated at one (1) unit for each thirty (30) minutes of time. Effective with dates of service December 1, 2010, providers will bill medical direction at one (1) unit for each fifteen (15) minutes of time.
- **Physical Status Modifiers:**

The final Anesthesia Services regulation posted on the website reflects an error in regard to risk factors. Section 8.310.14, Non Covered Services, item D, states that separate payment is not allowed for the modifiers related to the physical status of the patient, referred to as the risk modifiers. However, the wording from the prior regulation related to reimbursement in Section 8.310.5.15, Reimbursement, item D and D (4), was published in the final rule in error. The intent is to follow Medicare's rule related to non-coverage of risk modifiers, therefore, additional reimbursement will not be made for risk as stated in the Non Covered Services section. The Department will be proposing a rule that will make the necessary correction in the final document.

Effective with dates of service December 1, 2010, additional payment will not be allowed.

- **Qualifying Circumstances:** Prior to December 1, 2010, providers were given additional payment when CPT Qualifying Circumstance procedure codes were billed. These add-on procedure codes are 99100, 99116, 99135 and 99140. Effective with dates of service December 1, 2010, additional payment will not be made when these codes are billed.

A provider, who submits a claim for Qualifying Circumstances, will receive a denial message stating that the procedure is not covered for the date of service.

- **Neuraxial labor analgesia/anesthesia, CPT 01967 (Neuraxial labor analgesia/anesthesia for planned vaginal delivery),** is to be calculated at one (1) unit for each hour of neuraxial analgesia management. The calculation of time includes direct patient contact, management of adverse events, delivery and removal of the catheter. Reimbursement will be made at time units plus base units.

When an emergency cesarean is required, the provider will bill one (1) unit for each hour of neuraxial analgesia, CPT 01967. The CPT add-on code for the cesarean is 01968 (Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia). Time is calculated at one (1) unit for each fifteen (15) minutes during the cesarean.

- Add-on code for anesthesia/burns and debridement: For the add-on code involving burns or debridement, CPT 01953 (Anesthesia for second and third degree burn, excision or debridement with, each additional 9% total body surface area) providers must bill one (1) unit (**not time**) per additional 9% total body surface area or part thereof. Time units are to be billed with the primary code 01952 (Anesthesia for second and third degree burn, excision or debridement with, between 4% and 9% of total body surface area).
- Medical supervision: An anesthesiologist who is medically directing more than four (4) CRNA's and/or AA's must bill using modifier AD, Supervision, more than four procedures, and reimbursement will be made at three (3) base units per procedure.
- Pre-Anesthetic Exams/Cancelled Surgery: A pre-anesthetic examination and evaluation of a patient who does not undergo surgery due to elective cancellation of a service prior to the administration of anesthesia and/or surgical procedure may also be considered for payment.

A pre-anesthetic examination and evaluation of a patient who does not undergo surgery due to extenuating circumstances or those that threaten the well being of the patient after the administration of the anesthesia or after the procedure was started may also be considered for payment.

The above information provides some key changes in anesthesia billing and reimbursement. A complete copy of the Anesthesia Services regulations may be obtained from the Medical Assistance Division (MAD), 505-827-3156, or by accessing our website at [www.state.nm.us/hsd/mad/Index.html](http://www.state.nm.us/hsd/mad/Index.html). This document and a copy of the complete regulation should be made available to all billing staff to ensure that claims are submitted accurately.

Questions regarding this supplement should be directed to Rosemary Medrano, Benefits Bureau at (505) 827-1339.