Anesthesia and Interventional Pain Management Reimbursement Policy Update Coming Soon!

September 27, 2023

To ensure accurate reimbursement of anesthesia and interventional pain management services, we are updating our policy.

Effective January 1, 2024, the policy below will be implemented.

Responsibility	Action
HAP	1. Only reimburse professional anesthesia services when billed by the following: • Anesthesiologist • CRNA • Pediatric Anesthesiologist • Pediatric Critical Care physician • Other qualified pediatric subspecialties identified and approved by HAP 2. Will not reimburse chiropractors for anesthesia and/or pain management services. 3. Deny anesthesia/CRNA claims submitted on a UB 0492 claim form.
Provider	1. Submit anesthesia/CRNA claims on a CMS 1500 claim form 2. Pain Management Specialists must: a. Be credentialed by HAP as a Pain Management Specialist. b. Be separately contracted for Interventional Pain Management Services. c. Bill with contracted Tax ID d. Follow group and individual NPI guidelines in the Billing Manual e. Accept HAP fee schedule reimbursement 3. **Refer to and comply with all guidelines in the Anesthesia and Interventional Pain Management Services Reimbursement Guidelines chapter in the HAP Billing Manual. The manual can be found by logging in at hap.org and selecting *Quick Links*, then *Billing Manual*.**

The Billing Manual content is attached.

Anesthesia and Interventional Pain Management Reimbursement Policy

Anesthesia Reimbursement

Important Information about Anesthesia Reimbursement

- This policy:
  - Is intended to ensure providers are reimbursed based on the code(s) that correctly describe services rendered.
  - Addresses reimbursement of procedural or pain management services that are an integral part of anesthesia services, and anesthesia services that are an integral part of procedural pain management services.
- Practitioners and providers are responsible for submission of accurate claims.
- Coverage of service is based on the member's subscriber contract.
- Reimbursement is based on the provider's contractual agreement with HAP.
- Contracted providers must refer to other HAP contracted providers, including laboratory services (e.g., JVHL).
- Contracted facilities must use HAP contracted anesthesia providers.
- Contracted anesthesia providers must provide services in a contracted facility.
- Interventional pain management services requires a separate HAP contract, not included in the anesthesia contract.
- HAP may use reasonable discretion in interpreting and applying this policy to health care services provided.
- This policy does not address all issues related to reimbursement for services provided to HAP members. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, and are not limited to:
  - Legislative mandates
  - Physician or provider contract(s)
  - Enrollee's benefit coverage documents and/or other reimbursement
  - Referral/authorization policies
  - Medical drug policies
  - HAP Policies and Procedures
- HAP requires providers to bill in accordance with most current billing and coding guidelines.
- HAP will monitor claims for appropriate billing practices and take necessary action.

HAP may modify this policy at any time and publish the most current version in the HAP Billing Manual and posted in HAP secure provider portal.

Definitions

ASA	American Anesthesia Society of Anesthesiologists
RVG	Relative Value Guide
NCCI	National Correct Coding Initiative
CMS	Centers for Medicare and Medicaid Services

Anesthesia Crosswalk

The American Society of Anesthesiologists (ASA) CROSSWALK is a comprehensive guide that is published annually that identifies the anesthesia CPT codes (00100-01999), and alternate codes when appropriate, that most specifically describes the anesthesia service for a diagnostic or therapeutic CPT procedure code.

This reimbursement policy uses the American Society of Anesthesiologists (ASA) crosswalk, Centers for Medicare and Medicaid (CMS) National Coding Initiative (NCCI) Policy manual and CMS NCCI edits. Provider should always review the latest codes when billing for services.

Anesthesia codes must CROSSWALK to a surgical CPT/HCPCS code. Most non-invasive interventional pain injection codes for intractable pain management services, do not CROSSWALK to an anesthesia code. These codes may include the anesthetic agent within the code descriptor. A separate claim using an anesthesia code that does not CROSSWALK to the minor procedure, in most cases, would not be expected, under the same or different Tax ID. Modifier 59 would also not be appropriate .

This excludes postoperative pain procedures performed in conjunction with anesthesia, performed by an anesthesiologist, related to a surgery. Modifier 59 would be appropriate when appended to the postoperative CPT pain injection code performed at a separate encounter.

Refer to the Moderate (Conscious) Sedation section related to interventional pain management services.

Who Can Bill for Anesthesia Services

- HAP will only reimburse professional anesthesia services when billed by the following:
  - Anesthesiologist
  - CRNA
  - Pediatric Anesthesiologist
  - Pediatric Critical Care physician
- Claims should be submitted using the contracted anesthesia Group Tax ID and Group NPI.
- HAP will not reimburse chiropractors for anesthesia and/or pain management services.

Anesthesia Claim Forms

All anesthesia/CRNA claims must be submitted on a CMS (HCFA) 1500 claim form. Anesthesia/CRNA claims submitted on a UB 04 claim form will deny.

Anesthesia Reimbursement Methodology

When an anesthesiologist and CRNA are both present during a procedure and both are billing for reimbursement, HAP will split the payment 50/50. In this instance, neither the anesthesiologist nor the CRNA is eligible to be paid 100% of the associated reimbursement.

HAP will recognize for reimbursement the then current ASA RVG Codes 00100 thru 01999. HAP will calculate ABU reimbursement by adding the Base Units and Time Units, then multiplying that product by the contracted ABU per unit Conversion Factor.

HAP will not reimburse anesthesia services using surgical CPT Procedure Codes, when the CPT Procedure Code description states the procedure was performed without anesthesia, and radiologic services related to another diagnostic or therapeutic procedure.

All other Procedure Codes will be reimbursed in accordance with the reimbursement terms and conditions listed in the provider's contract.

Anesthesia Time

Anesthesia time is defined as the continuous presence of the anesthesia provider. It starts when the patient enters the specific anesthetizing location where the surgical procedure occurs and ends when the patient is placed under post-operative supervision. Submit anesthesia time to HAP in total time minutes versus fifteen (15) minute Time Units. HAP will convert the total time billed by the provider into fifteen (15) minute Time Units, rounding up to after 8 minutes.

For example

- If a procedure takes 37 minutes, HAP will convert this to 2 Time Units (37 minutes/15-minute units = 2.4-time units rounded, or 2-time units).
- If a procedure takes 38 minutes, HAP will convert this to 3-time units (38 minutes/15-minute units = 2.53-time units rounded, or 3-time units).

Claims submitted from 0 to 7 minutes will result in ZERO Time Units applied.

Anesthesia for Preventive Colonoscopy Services

- To be considered preventive, submit using codes 00811 and 00812 along with one of the following preventive modifiers in the FIRST modifier field:
  - 33 - Preventive Service
  - PT - Colorectal cancer screening test; converted to diagnostic test or other procedure

A valid anesthesia modifier, listed above, must be submitted in the second modifier field. The physical status modifier must be submitted in the third modifier field.

Example: 00811 33 QK P1 QS
00812 PT AA P1

Anesthesia Services Performed in a Free-Standing Ambulatory Surgery Center (Place of Service 24)

- Free-standing ambulatory surgery centers utilized for surgeries must be HAP credentialed and contracted.
- HAP requires anesthesia providers performing services at a free-standing ambulatory surgery center, to also be contracted under their anesthesia Tax ID.
- HAP will not reimburse Pain Management Specialists performing Interventional Pain Management Injections for chronic intractable pain in the Ambulatory Surgical setting as these are unrelated to a post-operative surgery. Refer to the Interventional Pain Management section. Interventional pain management injections must only be submitted for the office setting.

Anesthesia Services Performed in a Pain Clinic Office Setting (00100 – 01999)

- Physician offices are not considered ambulatory surgery centers and are not HAP credentialed and contracted to perform anesthesia services.
- HAP will not reimburse anesthesia services performed in a pain clinic office setting.

Anesthesia for Interventional Pain Management Injections – Unrelated to a Surgery by Surgeon

- According to the American Society of Anesthesiologists and the International Spine Intervention Society, minor pain management procedures such as epidural steroid injections, epidural blood patch, trigger point injections, sacroiliac joint injection, bursal injections, occipital nerve block and facet injections under most routine circumstances, require only local anesthesia.
- Anesthesia and moderate sedation services (00300, 00400, 00600, 00620, 00630, 01935-01936, 01991-01992, 99152-99153, 99156-99157) billed with pain management services (20552, 20553, 27096, 62273, 62320-62323, 64405, 64479, 64480, 64483, 64484, 64490-64495, 0228T, 0229T, 0230T, 0231T, G0260) for a patient 18 years of age or older will be denied unless a related surgical procedure 10021-69990 (other than a pain management procedure) is also present.

Group and Hospital Employed CRNA Services Performed in an Inpatient Hospital Setting (Place of Service 21)

- Hospital employed CRNA services bill a CMS 1500 claim form.
- Reimbursement will be in accordance with the contractual terms listed in the applicable hospital agreement.
- CRNAs employed by an anesthesiology group will be reimbursed per the group anesthesia agreement.

Modifiers Recognized for Payment or Informational

All anesthesia/CRNA ABU claims must include one of the modifiers listed below.

Required Anesthesia Modifiers	**All anesthesia services must be submitted with the required anesthesia modifier in the first modifier field. See Anesthesia for Preventive Colonoscopy Services in this chapter for exception. These modifiers identify whether a procedure was personally performed, medically directed, or medically supervised. HAP will adjust the allowed amount by the modifier percentage in the table below.**	**Reimbursement Percentage**
AA	Anesthesia services performed personally by an anesthesiologist	100%
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified CRNA providers	50%
QY	Medical direction of one qualified CRNA	50%
QX	CRNA service with medical direction by an anesthesiologist	50%
QZ	CRNA services not supervised by a physician	100%
Physical Status Modifiers	**CPT and ASA guidelines identify six levels of ranking for patient physical status. A Physical Status Modifier must be submitted with each ASA code, in addition to the valid anesthesia modifier. HAP nor CMS allows for additional reimbursement units for these codes.**	**No Additional Reimbursement Considered Informational**
P1	A physical status modifier for a normal heathy patient.	Informational
P2	A physical status modifier for a patient with mild systemic disease.	Informational
P3	A physical status modifier for a patient with severe systemic disease.	Informational
P4	A physical status modifier for a patient with severe systemic disease that is a constant threat to life.	Informational
P5	A physical status modifier for a moribund patient who is not expected to survive without the operation.	Informational
P6	A physical status modifier for a declared brain-dead patient whose organs are being removed foe donor purposes.	Informational
Qualifying Circumstances for Anesthesia	**Anesthesia services may be qualified further by submitting the codes below. These services are considered informational. HAP will not allow additional reimbursement for these codes.**	**No Additional Reimbursement Considered Informational**
99100	Anesthesia for patient of extreme age, younger than 1 year an old than 70	Informational
99116	Anesthesia complicated by utilization of total body hypothermia	Informational
99135	Anesthesia complicated by utilization of controlled hypotension	Informational
99140	Anesthesia complicated by emergency conditions	Informational

Other Modifiers

Other modifiers that are commonly used in anesthesia include: 25, 26, 50, 51 and 59. These modifiers will be used in the adjudication process for pricing claims, if appropriate. These modifiers are not billable on the ASA anesthesia codes 00100 – 01999.

Multiple General Anesthesia Services on Same Day

- Anesthesia providers need to:
  - Submit the ASA RVG code with the highest Base Unit when multiple surgical procedures are performed during the same surgical event.
  - Bill the total time required to perform all surgical procedures for this same surgical event.

NCCI Edits Anesthesia and Surgical Procedures

According to NCCI Edits, anesthesia for a surgical procedure is an included service and is not separately reportable. When anesthesia services are not separately reportable, physicians and facilities shall not unbundle components of anesthesia and report them. Interventional Pain Injections are minor procedures and would not require general anesthetic. Anesthesia is an inherent component of these injections.

OBSTETRICAL ANESTHESIA

Neuraxial Labor Analgesia Reimbursement Calculations

HAP will reimburse neuraxial labor analgesia (CPT code 01967) based on Base Unit Value plus Time Units. Service should be reported in Total Minutes and start and stop times. HAP will calculate one 15-minute unit for each 60 minutes of time reported. HAP will round up after 30 minutes and round down for 29 minutes or less. Modifying Units for physical status modifiers and qualifying circumstance codes will not be considered in addition to the Base Unit Value for labor or delivery anesthesia services.

Obstetric Add-On Codes

Obstetric Anesthesia often involves extensive hours and the transfer of anesthesia to a second physician. Due to these unique circumstances, HAP will consider for reimbursement, add-on CPT codes 01968 and 01969 (c-section anesthesia) when billed with the primary CPT code 01967 (by the same or different individual and qualified physician) for the same member. According to the ASA Crosswalk® time for add-on code 01968 or 01969 is reported separately as a surgical anesthesia service and is not added to the time reported for the labor anesthesia service.

Obstetric Anesthesia: Neuraxial Labor Analgesia Reimbursement Calculations

Example 1:
209 minutes (3 hours 29 minutes) are reported for labor and delivery services on a single claim line with CPT code 01967. The total time will be calculated as one 15-minute increment per each 60 minutes, rounded down for the additional 29 minutes. 209 / 60 = 3.4 (rounded down to 3-time units).

Example 2:
390 minutes (6 hours 30 minutes) are reported for labor and delivery services on a single claim line with CPT code 01967. The total time will be calculated as one 15-minute increment per each 60 minutes, rounded up for the additional 30 minutes. 390 / 60 = 6.5 (rounded up to 7-time units).

Procedural or Pain Management Codes Bundled into Anesthesia - Related to Post-Operative Surgical Procedures (Excluding Interventional Pain Management Injections)

- Anesthesia providers may identify these separate encounters for postoperative pain injections by appending modifier 59 [separate patient encounter] to their CPT/HCPCS codes.
- Documentation in the medical record must satisfy the criteria for the use of modifier 59. These services relate to an anesthesiologist's service performed after a surgical procedure 10021-69990, at a separate encounter (other than an interventional pain management injection.

Reporting Postoperative Pain Procedures in Conjunction with Anesthesia (No-Time Codes)

- This includes services performed by an anesthesiologist after a surgery has been performed.
- This excludes interventional pain management injections for chronic intractable pain, as they are not considered post-operative to a surgery.
- HAP will only reimburse selected non-anesthesia no-time services listed in the Relative Value Guide from the American Society of Anesthesiologists and listed in the provider's contract. These services must be provided by an anesthesiologist in an inpatient hospital, outpatient hospital, or ambulatory surgery center setting (place of service 21, 22, and 24) as a post-operative service that is performed by a surgeon.

Interventional Pain Management Injections

Important Information about Pain Management Injections

Pain Management Specialists:

- Must be credentialed by HAP as a Pain Management Specialist.
- Must be separately contracted for Interventional Pain Management Services.
- Must use HAP-contracted providers, including all laboratory services (e.g., JVHL).
- To ensure you're timely and accurately reimbursed by HAP for pain management services a separate NPI is needed.
- Must have a separate group billing NPI with YES line that includes a taxonomy '208'.
  For example:
    208VP0014X – Pain Medicine Interventional Pain Medicine
    208VP0000X – Pain Medicine Pain Medicine
- Must have an individual NPI that includes a taxonomy '208' as indicated above.
- Should not submit Interventional Pain Management services using a group NPI and contract that are specific to Anesthesia Services, '207'.
  For example:
    207LP2900X – Anesthesiology Pain Medicine
    207L00000X - Anesthesiology
- Submit using a contracted Tax ID.
- Accept HAP fee schedule for reimbursement.

For additional coverage information, be sure to refer to our benefit coverage policy:

- Log in at **hap.org**; select *More*, *Benefit Admin Manual*, then search for *Interventional Pain Management Services.*

Prior Authorization Requirements for Interventional Pain Management Services

Note: Be sure to verify if the member has benefit coverage for interventional pain management services prior to obtaining prior authorization. Members may not be balance billed regardless of authorization status.

- Prior authorization is required for all interventional pain injection services before services are rendered (both in the office setting and a site of service other than the office setting).
- Prior authorization does not guarantee payment of services.
- Prior authorization only covers the HAP contracted and credentialed Pain Management Specialists requesting and performing the service.
- Claims will deny for facilities and other provider specialties not credentialed as a Pain Management Specialist and not approved separately on the prior authorization.
- Other providers, including non-contracted, require Medical Director approval. If not obtained, these services are considered not medically necessary. Members may not be balance billed in this instance.
- For a complete list of prior authorization requirements:
  - Log in at **hap.org**; select *Quick Links*; *Procedure Reference Lists*; then:
    - *Prior Authorization List Summary*
    - *Services that Require Prior Authorization List*

Modifier 59 Proper Use

MLN Fact Sheet: MLN1783722 - Proper Use of Modifiers 59, XE, XP, XS, and XU (cms.gov)

- Don't use modifier 59 just because the code descriptors of the 2 codes are different.
- The Medicare National Correct Coding Initiative (NCCI) includes Procedure-to-Procedure (PTP) edits that define when you shouldn't report certain HCPCS or CPT codes together either in all situations or in most situations. These edits allow the following:
  - For NCCI PTP-associated edits that have a Correct Coding Modifier Indicator (CCMI) of "0," never report the codes together by the same provider for the same beneficiary on the same date of service. If you do report the codes together on the same date of service, the Column One code is eligible for payment and Medicare denies the Column Two code.
  - For NCCI PTP-associated edits that have a CCMI of "1," you may report the codes together only in defined circumstances by using specific NCCI PTP-associated modifiers.
- Refer to the National Correct Coding Initiative Policy Manual for Medicare Services, Chapter 1, for general information about the NCCI program, NCCI PTP-associated edits, CCMIs, and NCCI PTP-associated modifiers.
- One purpose of NCCI PTP-associated edits is to prevent payment for codes that report overlapping services except where the services are "separate and distinct." **Modifier 59 is an important NCCI PTP-associated modifier that providers often use incorrectly.**
- One of the common misuses of modifier 59 relates to the part of the definition of modifier 59 allowing its use to describe a "different procedure or surgery." The code descriptors of the 2 codes of a code pair edit describe different procedures, even though they may overlap. Don't report the 2 codes together if they're performed at the same anatomic site and same patient encounter, because they aren't considered "separate and distinct".
- Don't use modifiers 59 to bypass a PTP edit based on the 2 codes being "different procedures".
- Documentation must support:
  - Different session
  - Different procedure or surgery
  - Different site or organ system
  - Separate incision/excision
  - Separate lesion
  - Separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual
- Modifier 59 should never be used on:
  - Code combination not in NCCI
  - On two of the same codes

  Examples:
  Interventional Pain Management, non-invasive services are usually performed at one session or patient encounter, without surgical procedure by a surgeon.

Place of Service (POS) Coding Instructions

(Per Pub 100-04 Medicare Claims Processing Manual, transmittal 2679)

- Special Considerations for Outpatient Hospital Departments:
  - Physicians practitioners who perform services in a hospital outpatient department will use, at a minimum, POS 22 (Outpatient Hospital).
  - Code 22 (or other appropriate outpatient department POS code as described in transmittal 2679 referenced above) will be used unless the physician maintains separate office space in the hospital campus and that physician office space is not considered a provider-based department of the hospital as defined in 42.C.F.R. 413.65.
  - Physicians will use POS code 11 (office) when services are performed in a separately maintained physician office space in the hospital or on hospital campus and that physician office space is not considered a provider-based department of the hospital as defined in 42.C.F.R.413.6.
  - Use of POS code 11 (office) in the hospital outpatient department or on hospital campus is subject to the physician self-referral provisions set forth in 42.C.F.R.411.353 through 411.357.
- Special Considerations for Ambulatory Surgical Centers (Code 24):
  - Physicians/practitioners who perform services in a Medicare-participating ASC will use POS code 24 (ASC).
  - Physicians are not to use POS 11 (office) for ASC based services **unless the physician has an office at the same physical location of the ASC which meets all other requirements for operating a physician office at the same physical location of the ASC – including meeting the "distinct entity" criteria defined in the ASC State Operations Manual that precludes the ASC and an adjacent physician office from being open at the same time – and the physician service was actually performed in the office suite portion of the facility**. Refer to Appendix L – Guidance for Surveyors: Ambulatory Surgery Centers of the State Operations Manual.

ASC State Operations Manual

- An ASC does not have to be completely separate and distinct physically from another entity, if, and only if, it is temporally distinct. In other words, the same physical premises may be used by the ASC and other entities, so long as they are separated in their usage by time. For example:
  - Adjacent physician office: Some ASCs may be adjacent to the office(s) of the physicians who practice in the ASC. Where permitted under State law, CMS permits certain common, non-clinical spaces, such as a reception area, waiting room, or restrooms to be shared between an ASC and another entity, as long as they are never used by more than one of the entities at any given time, and as long as this practice does not conflict with State licensure or other State law requirements. **In other words, if a physician owns an ASC that is located adjacent to the physician's office, the physician's office may, for example, use the same waiting area, as long as the physician's office is closed while the ASC is open and vice-versa. The common space may not be used during concurrent or overlapping hours of operation of the ASC and the physician office**. Furthermore, care must be taken when such an arrangement is in use to ensure that the ASC's medical and administrative records are physically separate. During the hours that the ASC is closed, its records must be secure and not accessible by non-ASC personnel.
- It is not permissible for an ASC during its hours of operation to "rent out" or otherwise make available an OR or procedure room, or other clinical space, to another provider or supplier, including a physician with an adjacent office.

Interventional Pain Management Services Performed in a Pain Clinic Office Setting
Place of Service (POS) 11

- Interventional pain management services for chronic pain will only be reimbursed when performed in an office setting.
- For Place of Service 19, refer below to Outpatient Hospital and Ambulatory Surgery Center section.
- Interventional pain management services must be billed on the same claim using the CPT injection codes including all medication(s) as well as Moderate Conscious Sedation codes when applicable.

Example: Pain Management Physician Claim
62323 (anesthetic included in surgical procedure)
J1030
99152

Separate Claim under Different Tax ID
01938 QK 59 - inappropriate billing, no ASA Crosswalk to 62323
-Mod 59 inappropriate on anesthesia for same encounter
- Injection procedure does not represent a surgery on the spine and spinal code for 01938 to be submitted

Provider-Based Status Off-Campus – Use of POS 19

CMS Regulations 42 CRF 42 CFR § 413.65 – Requirements for a determination that a facility or an organization has provider-based status:

- A facility or organization is not entitled to be treated as provider-based simply because it or the main provider believe it is provider-based.
- Provider-based attestations are used by CMS to establish that a facility has met provider-based status determination requirements.
- An Off-Campus location must be located within a 35-mile radius (unless certain requirements are met).
- At least 75 percent of the patients served by the facility reside in the same zip code area.
- A provider-based facility is a facility that is operationally integrated with a main hospital (i.e., it operates under the same name, ownership, and administrative and financial control of the main hospital, exact match on name and address) such that it is permitted to bill for services under the hospital's tax identification number (TIN). For joint ventures with a non-hospital party, the facility must satisfy additional requirements.
- Medicare only allows so-called co-location if strict provider-based requirements are met relative to physical space, and failure to satisfy them can lead to a loss of provider-based status, including leasing space to a visiting specialist.
- The appropriate Place of Service is required. Services performed in a Freestanding physician office/Pain Clinic that does not meet CMS criteria as Provider-Based Off-Campus, should be submitted using POS 11 (office).

Monitored Anesthesia Care (MAC)

Monitored anesthesia care will **not** be routinely reimbursed for services related to interventional pain management injections for chronic intractable pain, regardless of where the services are performed. This includes the following codes CPT codes:

Code	Description
01937	Anesthesia for percutaneous image-guided injection, drainage or aspiration procedures on the spine or spinal cord; cervical or thoracic
01938	Anesthesia for percutaneous image-guided injection, drainage or aspiration procedures on the spine or spinal cord; lumbar or sacral
01939	Anesthesia for percutaneous image-guided destruction procedures by neurolytic agent on the spine or spinal cord; cervical or thoracic
01940	Anesthesia for percutaneous image-guided destruction procedures by neurolytic agent on the spine or spinal cord; lumbar or sacral
01941	Anesthesia for percutaneous image-guided neuromodulation or intravertebral procedures (eg, kyphoplasty, vertebroplasty) on the spine or spinal cord; cervical or thoracic
01942	Anesthesia for percutaneous image-guided neuromodulation or intravertebral procedures (eg, kyphoplasty, vertebroplasty) on the spine or spinal cord; lumbar or sacral
01991	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different physician or other qualified health care professional); other than prone position
01992	Anesthesia for diagnostic or therapeutic nerve blocks and injections; prone position

Interventional Pain Injections and Anesthesia

According to CMS Local Coverage Determinations, Use of Moderate or Deep Sedation, General Anesthesia and Monitored Anesthesia Care (MAC) is usually unnecessary or rarely indicated for these procedures and not considered medically reasonable and necessary and therefore may be denied. Even in patients with a needle phobia and anxiety, typically oral anxiolytics suffice for the following:

- Sacroiliac injections
- Lumbar epidural injections
- Facet joint injections
- Medial branch blocks
- Facet joint radiofrequency neurotomy, and trigger points

General anesthesia or monitored anesthesia care (MAC) is rarely, if ever, required for these injections. Standard medical practice utilizes local anesthesia or moderate (conscious) sedation.

General anesthesia is considered not reasonable and necessary for facet joint interventions. Neither conscious sedation nor monitored anesthesia care are routinely necessary for intraarticular facet joint injections or medial branch blocks and are not routinely reimbursable. Individual consideration may be given upon redetermination (appeal) for payment in rate, unique circumstances if the medical necessity of sedation is unequivocal and clearly documented in the medical record. Frequent reporting of these services together may trigger focused medical review.

Moderate (Conscious) Sedation

HAP may reimburse for moderate (conscious) sedation services:

- When performed in an office setting.
- When the Pain Management Specialist submits codes 99151-99153 along with their interventional pain injection services.
- Services will be reimbursed for pain management specialists for these services when billed under their contracted pain management Tax ID and NPI.
- When moderate sedation does not include monitored anesthesia care (CPT codes 00100-01999).

Outpatient Hospitals and Ambulatory Surgery Centers

Below are specific guidelines for outpatient hospitals and ambulatory surgery centers.

For	Per CMS Guidelines
Outpatient Hospital and Ambulatory Surgery Center	• Physicians and practitioners who perform services in a hospital outpatient department will use, at a minimum, POS code 22 (Outpatient Hospital). • Code 22 (or other appropriate outpatient department POS code) will be used unless the physician maintains separate office space in the hospital or on the hospital campus and that physician office space is not considered a provider-based department of the hospital as defined in 42.C.F.R. 413.65. • Physicians will use POS code 11 (Office) when services are performed in a separately maintained physician office space in the hospital or on hospital campus and that physician office space is not considered a provider-based department of the hospital as defined in 42.C.F.R. 413.6. • Use of POS code 11 (Office) in the hospital outpatient department or on hospital campus is subject to the physician self-referral provisions set forth in 42 C.FG.R. 411.353 through 422.357.
Outpatient Hospital – Off Campus POS code 19	• The Facility must meet the criteria listed in the regulations before a main provider may bill for services of a clinic as if the facility is provider-based, or before it includes costs of those services on its cost report. • Physician office and Pain Management Clinic services that do not meet the criteria as provider-based outpatient department of a hospital, should not be submitted using Place of Service 19. • For clinic visits and services performed in the hospital setting, HAP does not allow split-billing of provider-based clinic services. This applies whether the clinic is located in an on-campus-outpatient hospital setting (POS 22), or an off campus outpatient hospital (POS 19), and whether or not the clinic uses the hospital tax identification number. • Do not split-bill clinic-based services, billing part of the service as a facility charge, and part of the service as a professional charge using POS 19 or 22 or a professional revenue code. • All professional services provided in an outpatient clinic setting are to be billed on a CMS1500 claim form or electronic equivalent, using POS 11 Office. Professional claims will be reimbursed according to the applicable professional fee schedule. • https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/A03030.PDF • https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE19007.pdf
Ambulatory Surgery Center	• Physicians and practitioners who perform services in a Medicare-participating ASC will use POS code 24 (ASC). • Physicians are not to use POS 11 (office) for ASC based services unless the physician has an office at the same physical location of the ASC which meets all other requirements for operating as a physician office at the same physical location as the ASC – including meeting the "distinct entity" criteria defined in the ASC State Operations Manual that precludes the ASC and an adjacent physician office from being open at the same time – and the physicians service was actually performed in the office suite portion of the facility. That information is in Appendix L of that manual which is at: Medicare State Operations Manual (hhs.gov) https://wayback.archive-it.org/2744/20180818091615/https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM7631.pdf
Off-Campus Hospital Based Department Requirements	• Must meet CMS compliance with rules and regulations. • Must be located no more than 35 miles from Main Provider. • Must match financials with the same Tax Identification Number. • Address must match exactly between Main Provider and OC Provider Based Department. • HAP may request the CMS Provider Based Attestation application and approval documents. • CMS Enrollment documents (855's).

References & Resources

1. Interventional Pain Management Services, located in the Benefit Administration Policy.
2. Epidural Steroid Injections for Pain Management L39054 https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?LCDId=39054
3. Billing and Coding: Epidural Steroid Injections for Pain Management A58777 https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleid=58777&ver=7&=
4. Facet Joint Interventions for Pain Management (L38841) https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=38841