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## **714 ANESTHESIA SERVICES**

The New Mexico Medicaid program (Medicaid) pays for medically necessary health services furnished to eligible recipients. To help New Mexico recipients receive necessary services, the New Mexico Medical Assistance Division (MAD) pays for covered anesthesia services.

This section describes eligible providers, covered services, service limitations, and general reimbursement methodology.

### **714.1 Eligible Providers**

Upon approval of New Mexico Medical Assistance Program Provider Participation Agreements by MAD, the following providers are eligible to be reimbursed for providing anesthesia services:

1. Individuals licensed to practice medicine or osteopathy who meet one of the following criteria:
  - A. Certified or eligible to be certified by the American Board of Anesthesiology; or
  - B. Engaged in the specialty practice of anesthesiology.

Payments are made to individuals or the group practices which they form.

2. Nurse anesthetists certified by the American Association of Nurse Anesthetists Council of Certification and licensed as registered nurses, within the scope of their practice and specialty as defined by state law.

Once enrolled, providers receive a packet of information, including Medicaid program policies, billing instructions, utilization review instructions, and other pertinent material from MAD. Providers are responsible for ensuring that they have received these materials and for updating them as new materials are received from MAD.

### **714.2 Provider Responsibilities**

Providers who furnish services to Medicaid recipients must comply with all specified Medicaid participation requirements. See Section MAD-701, GENERAL PROVIDER POLICIES.

Providers must verify that individuals are eligible for Medicaid at the time services are furnished and determine if Medicaid recipients have other health insurance.

Providers must maintain records which are sufficient to fully disclose the extent and nature of the services provided to recipients. See Section MAD-701, GENERAL PROVIDER POLICIES. Documentation of complications, emergency conditions, and physical status of recipients is required for payment based on additional units and reimbursement. For purposes of this section, an "emergency" is defined as a situation existing when delay in treating the recipient would lead to a significant threat to life or body part.

### **714.3 Covered Services**

Medicaid covers anesthesia and monitoring services which are medically necessary for performance of surgical or diagnostic procedures, as required by the condition of the recipient. All services must be provided within the limits of Medicaid benefits, within the scope and practice of anesthesia as defined by state law and in accordance with applicable federal and state and local laws and regulations.

### **714.4 Prior Approval and Utilization Review**

All Medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See Section MAD-705, PRIOR APPROVAL AND UTILIZATION REVIEW. Once enrolled, providers receive instructions and documentation forms necessary for prior approval and claims processing.

**714.41 Prior Approval** Certain procedures or services can require prior approval from MAD or its designee. Services for which prior approval was obtained remain subject to utilization review at any point in the payment process.

**714.42 Eligibility Determination** Prior approval of services does not guarantee

that individuals are eligible for Medicaid. Providers must verify that individuals are eligible for Medicaid at the time services are furnished and determine if Medicaid recipients have other health insurance.

**714.43 Reconsideration** Providers who disagree with prior approval request denials and other review decisions can request a re-review and a reconsideration. See Section MAD-953, RECONSIDERATION OF UTILIZATION REVIEW DECISIONS.

### **714.5 Noncovered Services**

Anesthesia services are subject to the limitations and coverage restrictions which exist for other Medicaid services. See Section MAD-602, GENERAL NONCOVERED SERVICES.

### **714.6 Reimbursement**

Anesthesia providers must submit claims for reimbursement on the HCFA-1500 claim form or its successor. See Section MAD-702, BILLING FOR MEDICAID SERVICES. Once enrolled, providers receive instructions on documentation, billing, and claims processing.

Reimbursement for anesthesia services is made at the lesser of the following:

1. The provider's billed charge; or
  2. The maximum allowed by MAD for the specific service or procedure.
- (A) The provider's billed charge must be their usual and customary charge for services.
- (B) "Usual and customary charge" refers to the amount which the provider charges the general public in the majority of cases for a specific procedure or service.

**714.61 Reimbursement Units** Reimbursement for anesthesia services is calculated using anesthesia "base units", units for time and units for risk.

- (A) Each surgical anesthesia procedure is assigned a specific number of relative value units which becomes the "base unit" for the procedure. Units of time and units for risk are also allowed for the procedure. Reimbursement is calculated by multiplying the total number of units by the dollar amount allowed for each unit.
- (B) The dollar amounts allowed per anesthesia unit vary depending on who furnishes the service. Separate rates are established for a physician anesthesiologist, a medically directed Certified Registered Nurse Anesthesiologist (CRNA) and a non-directed CRNA.
- (C) Time units vary, depending on the service. For anesthesia provided directly by a physician anesthesiologist or a CRNA, one (1) time unit is allowed for each fifteen (15) minute period a recipient is under anesthesia. For medical direction, one (1) time unit is allowed for each thirty (30) minute period.
- (D) Risk factor modifiers are used to describe the relative risk associated with general anesthesia to a particular recipient. Performing anesthesia providers are reimbursed for additional units only if risk factor modifiers are indicated on the claim.

**714.62 Medical Direction** Medical direction by a physician, other than the surgeon or assistant surgeon, to a certified nurse anesthetist (CRNA) is payable using the following methodologies:

1. For medical direction of two (2) nurse anesthetists performing two (2) concurrent procedures, the base units are reduced by ten percent (10%);
2. For medical direction of three (3) nurse anesthetists performing three (3) concurrent procedures, the base units are reduced by twenty-five percent (25%); and
3. For medical direction of four (4) nurse anesthetists performing four (4) concurrent procedures, the base units are reduced by forty percent (40%).

- (A) Time units for medical direction are allowed at one (1) time unit for each thirty (30) minute interval.
- (B) All the following requirements must be met before anesthesiologists are reimbursed for medical direction:
  - 1. The anesthesiologist does not perform any other service during the same period of time;
  - 2. The anesthesiologist cannot furnish anesthesia and provide medical direction concurrently;
  - 3. The anesthesiologist provides pre-anesthesia examinations or evaluations;
  - 4. The anesthesiologist participates in the anesthesia plan, including induction and emergence;
  - 5. The anesthesiologist monitors the course of anesthesia administration at frequent intervals;
  - 6. The anesthesiologist remains physically present and available in the operating suite for immediate diagnosis and treatment of emergencies; and
  - 7. The anesthesiologist provides any indicated post-anesthesia care.
- (C) Anesthesia claims are not payable if the surgery is not a Medicaid benefit or if any required documentation was not obtained.

**714.63 Monitored Anesthesia Care** Medically necessary monitored anesthesia care services are reimbursed at base units plus time units.

- (A) "Monitored anesthesia care" as defined by the American Society of Anesthesiologists, includes:
  - 1. Performance of a preanesthetic examination and evaluation;

2. Prescription of the anesthetic care required;
  3. Continuous intraoperative monitoring by a physician anesthesiologist or qualified Certified Registered Nurse Anesthetist of the patient's physiological signs;
  4. Administration of medication or other pharmacologic therapy as can be required for the diagnosis and treatment of emergencies; and
  5. Provision of indicated postoperative anesthesia care.
- (B) Medical direction for monitored anesthesia is reimbursed if it meets the medical direction requirements.

**714.64 Epidural Rates** Reimbursement for an initial epidural is paid using the base units for the procedure plus time units required to perform the initial procedure. No additional units for risk factors or time can be billed for epidural anesthesia. All subsequent epidural injections are paid at one (1) unit per injection.

**714.65 Performance of Standard Procedures** If an anesthesiologist performs procedures which are generally performed by other physicians without specific anesthesia training, such as local anesthesia or an injection, the anesthesiologist is reimbursed the fee schedule amount for performance of the procedure. Reimbursement is not made for base units, units for time or units for risk.