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**TITLE 8 SOCIAL SERVICES**  
**CHAPTER 310 HEALTH CARE PROFESSIONAL SERVICES**  
**PART 5 ANESTHESIA SERVICES**

**8.310.5.1 ISSUING AGENCY:** New Mexico Human Services Department (HSD).  
[2/1/95; 8.310.5.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 6/1/03; A, 11/1/10]

**8.310.5.2 SCOPE:** The rule applies to the general public.  
[2/1/95; 8.310.5.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 6/1/03]

**8.310.5.3 STATUTORY AUTHORITY:** The New Mexico medicaid program and other health care programs are administered pursuant to regulations promulgated by the federal department of health and human services under the Social Security Act as amended or by state statute. See NMSA 1978, Section 27-2-12 et seq.  
[2/1/95; 8.310.5.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 6/1/03; A, 11/1/10]

**8.310.5.4 DURATION:** Permanent  
[2/1/95; 8.310.5.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 6/1/03]

**8.310.5.5 EFFECTIVE DATE:** February 1, 1995, unless a later date is cited at the end of a section.  
[2/1/95; 8.310.5.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 6/1/03; A, 11/1/10]

**8.310.5.6 OBJECTIVE:** The objective of these rules is to provide instruction for the service portion of the New Mexico medicaid program.  
[2/1/95; 8.310.5.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 6/1/03; A, 11/1/10]

**8.310.5.7 DEFINITIONS:** [RESERVED]

**8.310.5.8 MISSION STATEMENT:** To reduce the impact of poverty on people living in New Mexico and to assure low income and individuals with disabilities in New Mexico equal participation in the lives of their communities.  
[2/1/95; 8.310.5.8 NMAC - Rn, 8 NMAC 4.MAD.002, 6/1/03; A, 11/1/10]

**8.310.5.9 ANESTHESIA SERVICES:** The medical assistance division (MAD) pays for medically necessary health services furnished to eligible recipients. To help New Mexico eligible recipients receive medically necessary services, MAD pays for covered anesthesia services.  
[2/1/95; 8.310.5.9 NMAC - Rn, 8 NMAC 4.MAD.714 & A, 6/1/03; A, 11/1/10]

**8.310.5.10 ELIGIBLE PROVIDERS:**

A. Health care to eligible recipients is furnished by a variety of providers and provider groups. The reimbursement and billing for these services is administered by MAD. Upon approval of a New Mexico MAD provider participation agreement by MAD or its designee, licensed practitioners, facilities and other providers of services that meet applicable requirements are eligible to be reimbursed for furnishing covered services to eligible recipients. A provider must be enrolled before submitting a claim for payment to the MAD claims processing contractors. MAD makes available on the HSD/MAD website, on other program-specific websites, or in hard copy format, information necessary to participate in health care programs administered by HSD or its authorized agents, including program rules, billing instructions, utilization review instructions, and other pertinent materials. When enrolled, a provider receives instruction on how to access these documents. It is the provider's responsibility to access these instructions, to understand the information provided and to comply with the requirements. The provider must contact HSD or its authorized agents to obtain answers to questions related to the material or not covered by the material. To be eligible for reimbursement, a provider must adhere to the provisions of the MAD provider participation agreement and all applicable statutes, regulations, and executive orders. MAD or its selected claims processing contractor issues payments to a provider using electronic funds transfer (EFT) only. Providers must supply necessary information in order for payment to be made. Eligible providers include:

(1) individuals licensed to practice medicine or osteopathy who are certified or eligible to be certified by the American board of anesthesiology; payments are made to an individual provider or the group practices to

which they belong; for physicians not certified or eligible to be certified by the American board of anesthesiology, anesthesia services are limited to their scope of practice as determined by the medical board;

(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; and

(3) anesthesiology assistants certified by the national commission on the certification of anesthesiology assistants (NCCAA) and licensed as anesthesiology assistants within the scope of their practice and specialty as defined by state law;

B. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must also enroll as a provider with the coordinated services contractor and follow that contractor's instructions for billing and for authorization of services.

[2/1/95; 8.310.5.10 NMAC - Rn, 8 NMAC 4.MAD.714.1 & A, 6/1/03; A, 11/1/10]

**8.310.5.11 PROVIDER RESPONSIBILITIES:** 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.

A. A provider who furnishes services to medicaid and other health care programs eligible recipients must comply with all federal and state laws, regulations, and executive orders relevant to the provision of medical services as specified in the MAD provider participation agreement. A provider must adhere to the MAD program rules and instruction as specified in this manual and its appendices, and program directions and billing instruction as specified in this manual and its appendices, and program directions and billing instructions, as updated. A provider is also responsible for following coding manual guidelines and CMS correct coding initiatives, including not improperly unbundling or up-coding services. See 8.302.1 NMAC, *General Provider Policies*.

B. A provider must verify that individuals are eligible for a specific health care program administered by HSD and its authorized agents, and must verify the eligible recipient's enrollment status at the time services are furnished. A provider must determine if an eligible recipient has other health insurance. A provider must maintain records that are sufficient to fully disclose the extent and nature of the services provided to an eligible recipient. See 8.302.1 NMAC, *General Provider Policies*.

[2/1/95; 8.310.5.11 NMAC - Rn, 8 NMAC 4.MAD.714.2, 6/1/03; A, 11/1/10]

**8.310.5.12 COVERED SERVICES:** MAD covers anesthesia and monitoring services which are medically necessary for performance of surgical or diagnostic procedures, as required by the condition of the eligible recipient. All services must be provided within the limits of MAD 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.

[2/1/95; 8.310.5.12 NMAC - Rn, 8 NMAC 4.MAD.714.3, 6/1/03; A, 11/1/10]

**8.310.5.13 PRIOR AUTHORIZATION AND UTILIZATION REVIEW:** All MAD 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 8.302.5 NMAC, *Prior Authorization and Utilization Review*. The provider must contact HSD or its authorized agents to request utilization review instruction. It is the provider's responsibility to access these instructions or ask for paper copies to be provided, to understand the information provided, to comply with the requirements, and to obtain answers to questions not covered by these materials. When services are billed to and paid by a coordinated services contractor authorized by HSD, the provider must follow that contractor's instructions for authorization of services.

A. **Prior authorization:** Certain procedures or services can require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process, including after payment has been made. See Subsection A of 8.311.2.16 NMAC, *emergency room services*.

B. **Eligibility determination:** Prior authorization of services does not guarantee that an individual is eligible for medicaid or other health care programs. A provider must verify that an individual is eligible for a specific program at the time services are furnished and must determine if an eligible recipient has other health insurance.

C. **Reconsideration:** A provider who disagrees with prior authorization request denials and other review decisions can request a re-review and a reconsideration. See Section MAD-953 [8.350.2 NMAC], *Reconsideration of Utilization Review Decisions*.

[2/1/95; 8.310.5.13 NMAC - Rn, 8 NMAC 4.MAD.714.4, 6/1/03; A, 11/1/10]

**8.310.14 NONCOVERED SERVICES:** Anesthesia services are subject to the limitations and coverage restrictions which exist for other MAD services. See 8.301.3 NMAC, *General Noncovered Services*.

A. When a provider performing the medical or surgical procedure also provides a level of anesthesia lower in intensity than moderate or conscious sedation, such as a local or topical anesthesia, payment for this service is considered to be part of the underlying medical or surgical service and will not be covered in addition to the procedure.

B. An anesthesia service is not payable if the medical or surgical procedure is not a medicaid or other health care benefit.

C. Separate payment is not allowed for qualifying circumstances; payment is considered bundled into the anesthesia allowance.

D. Separate payment is not allowed for modifiers (modifiers that begin with the letter "P") that are used to indicate that the anesthesia was complicated by the physical status of the patient.

[2/1/95; 8.310.5.14 NMAC - Rn, 8 NMAC 4.MAD.714.5, 6/1/03; A, 11/1/10]

**8.310.5.15 REIMBURSEMENT:**

A. An anesthesia provider must submit claims for reimbursement on the CMS 1500 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. 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.

B. The provider's billed charge must be their usual and customary charge for services.

C. "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.

D. **Reimbursement units:** Reimbursement for anesthesia services is calculated using the MAD fee schedule anesthesia "base units" plus units for time.

(1) Each anesthesia procedure is assigned a specific number of relative value units which becomes the "base unit" for the procedure. Units of time are also allowed for the procedure. Reimbursement is calculated by multiplying the total number of units by the conversion factor allowed for each unit.

(2) The reimbursement per anesthesia unit varies depending on who furnishes the service. Separate rates are established for a physician anesthesiologist, a medically-directed certified registered nurse anesthetist (CRNA), anesthesiology assistant (AA) and a non-directed CRNA.

(3) For anesthesia provided directly by a physician anesthesiologist, CRNA, or an anesthesiology assistant, one time unit is allowed for each 15- minute period an eligible recipient is under anesthesia. For medical direction, one time unit is allowed for each 15- minute period.

E. **Medical direction:** Reimbursement is made at 50 percent of the full anesthesia service amount for medical direction by a physician anesthesiologist who is not the surgeon or assistant surgeon, for directing an anesthesiology resident, a registered nurse anesthetist (CRNA) or an anesthesiology assistant (AA). Reimbursement is made at 50 percent of the full anesthesia service amount for the anesthesia service provided by the medically directed anesthesiology resident, CRNA or AA. Medical direction occurs if the physician medically directs qualified practitioners in two, three, or four concurrent cases and the physician performs the activities described below. Concurrency is defined with regard to the maximum number of procedures that the physician is medically directing within the context of a single procedure and whether these other procedures overlap each other. Concurrency is not dependent on each of the cases involving an eligible recipient. For example, if an anesthesiologist directs three concurrent procedures, two of which involve non-eligible recipients and the remaining a MAD eligible recipient, this represents three concurrent cases.

(1) Time units for medical direction are allowed at one time unit for each 15- minute interval.

(2) Anesthesia claims are not payable if the surgery is not a medicaid benefit or if any required documentation was not obtained.

(3) Medical direction is a covered service only if the physician:

- (a) performs a pre-anesthesia examination and evaluation; and
- (b) prescribes the anesthesia plan; and

(c) personally participates in the most demanding procedures of the anesthesia plan including induction and emergence; and

(d) ensures that any procedures in the anesthesia plan that he/she does not perform are performed by a qualified anesthetist; and

(e) monitors the course of anesthesia administration at frequent intervals; and

(f) remains physically present and available for immediate diagnosis and treatment of emergencies; and

(g) provides indicated post-anesthesia care.

(4) For medical direction, the physician must document in the medical record that he performed the pre-anesthetic exam and evaluation, provided indicated post-anesthesia care, was present during some portion of the anesthesia monitoring, and was present during the most demanding procedures, including induction and emergence, where indicated.

(5) A physician who is concurrently directing the administration of anesthesia to not more than four surgical patients may not ordinarily be involved in furnishing additional services to other patients. Addressing an emergency of short duration in the immediate area, administering an epidural or caudal anesthetic to ease labor pain, or periodic, rather than continuous, monitoring of an obstetrical patient does not substantially diminish the scope of control exercised by the physician in directing the administration of anesthesia to surgical patients. Medical direction criteria are met even though the physician responds to an emergency of short duration.

(6) While directing concurrent anesthesia procedures, a physician may receive patients entering the operating suite for the next surgery, check or discharge patients in the recovery room, or handle scheduling matters without affecting fee schedule payment.

(7) If a physician leaves the immediate area of the operating suite for other than short durations or devotes extensive time to an emergency case or is otherwise not available to respond to the immediate needs of the surgical patient, the physician's services to the surgical patients are supervisory in nature. Medical direction cannot be billed.

**F. Monitored anesthesia care:** Medically necessary monitored anesthesia care (MAC) services are reimbursed at base units plus time units.

(1) "Monitored anesthesia care" is anesthesia care that involves the intraoperative monitoring by a physician or qualified practitioner under the medical direction of a physician, or of the eligible recipient's vital physiological signs in anticipation of the need for administration of general anesthesia, or of the development of adverse physiological eligible recipient reaction to the surgical procedure and includes:

(a) performance of a pre-anesthetic examination and evaluation;

(b) prescription of the anesthesia care required;

(c) continuous intraoperative monitoring by a physician anesthesiologist or qualified certified registered nurse anesthetist of the eligible recipient's physiological signs;

(d) administration of medication or other pharmacologic therapy as can be required for the diagnosis and treatment of emergencies; and

(e) provision of indicated postoperative anesthesia care.

(2) For MAC, documentation must be available to reflect pre- and post-anesthetic evaluations and intraoperative monitoring.

(3) Medical direction for monitored anesthesia is reimbursed if it meets the medical direction requirements.

**G. Medical supervision:** If an anesthesiologist is medically directing more than four CRNAs, the service must be billed as medically supervised rather than medically directed anesthesia services. The MAD payment to the CRNA will be 50 percent of the MAD allowable amount for the procedure. Payment to the anesthesiologist will be based on three base units per procedure when the anesthesiologist is involved in furnishing more than four procedures concurrently or is performing other services while directing the concurrent procedure.

**H. Obstetric anesthesia:** Reimbursement for neuraxial labor anesthesia is paid using the base units plus one unit per hour for neuraxial analgesia management including direct patient contact time (insertion, management of adverse events, delivery, and removal).

**I. Unusual circumstances:** When it is medically necessary for both the CRNA and the anesthesiologist to be completely and fully involved during a procedure, full payment for the services of each provider is allowed. Documentation supporting the medical necessity for both must be noted in the patient's record.

**J. Pre-anesthetic exams/cancelled surgery:** A pre-anesthetic examination and evaluation of a patient who does not undergo surgery may also be considered for payment. Payment is determined under the physician fee schedule for the medical or surgical service.

**K. 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 or units for time.

L. **Add-on codes for anesthesia:** Add-on codes for anesthesia involving burn excisions or debridement and obstetrical anesthesia are paid in addition to the primary anesthesia code. Anesthesia add-on codes are priced differently than multiple anesthesia codes. Only the base unit of the add-on code will be allowed. All anesthesia time must be reported with the primary anesthesia code. There is an exception for obstetrical anesthesia. MAD requires for the obstetrical add-on codes, that the anesthesia time be separately reported with each of the primary and the add-on codes based on the amount of time appropriately associated with either code. Both the base unit and the time units for the primary and the add-on obstetrical anesthesia codes are recognized.

M. **Anesthesia services furnished by the same physician providing the medical and surgical service:**

(1) A physician who both performs and provides moderate sedation for medical/surgical services will be paid for the conscious sedation consistent with CPT guidelines; however, a physician who performs and provides local or minimal sedation for these procedures cannot bill and cannot be paid separately for the sedation services. The continuum of complexity in anesthesia services (from least intense to most intense) ranges from:

- (a) local or topical anesthesia; to
- (b) moderate (conscious) sedation; to
- (c) regional anesthesia; to
- (d) general anesthesia.

(2) Moderate sedation is a drug-induced depression of consciousness during which a patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. It does not include minimal sedation, deep sedation or monitored anesthesia care. If the physician performing the procedure also provides moderate sedation for the procedure, payment may be made for conscious sedation consistent with CPT guidelines; however, if the physician performing the procedure provides local or minimal sedation for the procedure, no separate payment is made for the local or minimal sedation service.

N. **Reimbursement for services furnished by interns or residents:**

(1) Reimbursement in an approved teaching program: reimbursement for services furnished by an intern or a resident in a hospital with an approved teaching program or services furnished in another hospital that participates in a teaching program is made through an institutional reimbursement; MAD cannot be billed directly by an intern or a resident for these services.

(2) Services performed in an outpatient and an emergency room setting: medical or surgical services performed by an intern or a resident in a hospital outpatient department or emergency room that are unrelated to educational services, are reimbursed according to the fee schedule for physician services when all of the following provisions are met:

- (a) services are identifiable physician services that are performed by the physician in person; and
- (b) services must contribute to the diagnosis or treatment of the eligible recipient's medical condition; and
- (c) an intern or resident is fully licensed as a physician; and
- (d) services are performed under the terms of a written contract or agreement and are separately identified from services required as part of the training program; and
- (e) services are excluded from outpatient hospital costs; when these criteria are met, the services are considered to have been furnished by the practitioner in their capacity as a physician and not as an intern or resident.

(3) Services of an assistant surgeon in an approved teaching program:

- (a) MAD does not pay for the services of an assistant surgeon in a facility with approved teaching program since a resident is available to perform services, unless the following exceptional medical circumstances exist:
  - (i) an assistant surgeon is needed due to unusual medical circumstances;
  - (ii) the surgery is performed by a team of physicians during a complex procedure; or
  - (iii) the presence of, and active care by, a physician of another specialty is necessary during the surgery due to the eligible recipient's medical condition.

(b) This reimbursement rule may not be circumvented by private contractors or agreements entered into by a hospital with a physician or a physician group.

[2/1/95; 8.310.5.15 NMAC - Rn, 8 NMAC 4.MAD.714.6 & A, 6/1/03; A, 11/1/10; A, 4/1/11]

**HISTORY OF 8.310.5 NMAC:**

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:  
MAD Rule 310.27, Anesthesia Services, filed 7/2/90.

History of Repealed Material:

MAD Rule 310.27, Anesthesia Services, filed 7/2/90 - Repealed effective 2/1/95.