Chapter 1 Section 9

Anesthesia

Issue Date: August 26, 1985
Authority: 32 CFR 199.4(c)(2)(vii), (c)(2)(viii), and 32 CFR 199.6(c)

1.0 CPT[1] PROCEDURE CODE RANGE

00100 - 01999

2.0 APPLICABILITY

The policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by the TRICARE Management Activity (TMA) and specifically included in the network provider agreement.

3.0 ISSUE

How is reimbursement for anesthesia services to be determined?

4.0 POLICY

4.1 Procedure codes. Claims are to be billed using the Current Procedural Terminology, 4th Edition (CPT-4) anesthesia codes.

4.2 Payment. Payment is calculated by multiplying the applicable conversion factor by the appropriate number of base units plus time units for each code.

4.2.1 There are two conversion factors--one for physicians and one for non-physicians, and the conversion factors are adjusted by wage indexes for each locality. The locality-specific conversion factors are adjusted in the same manner applied to CHAMPUS Maximum Allowable Charges (CMACs). That is, the current contractor-maintained conversion factors are compared to the Medicare locality-specific conversion factors, and the conversion factors are reduced a maximum of 15% a year or to the Medicare level.

4.2.2 Base units for each procedure are derived from the Medicare Anesthesia Relative Value Guide. Time units are 15 minutes, and any fraction of a unit is considered a whole unit. Time units will be as submitted on the claim.

4.3 Files provided to contractors. Each year the contractors will receive a file which contains the conversion factors (two per locality) along with the number of base units per CPT-4 code.

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4.4 Identification of provider. Since payment rates distinguish between physicians and non-physicians, each anesthesia claim must identify who provided the anesthesia. In those cases where part of the anesthesia service is provided by an anesthesiologist and the remainder by a nonphysician anesthetist, the claim(s) must identify exactly the services provided by each type of provider, so that the appropriate payment level can be used.

4.5 Anesthesia administered by operating surgeon. Administration of general anesthesia by the operating surgeon is not covered. If the surgeon bills a single charge which includes both the surgery and the anesthesia, a breakdown of the charge should be obtained and the anesthesia services denied. When a breakdown of charges is not available, payment will be based on the allowable charge for the surgery alone.

4.6 Total payment. Generally the total amount allowed or anesthesia provided by an anesthesiologist and a nonphysician anesthetist cannot exceed what would have been allowed had the anesthesia been provided only by an anesthesiologist. In no case can it exceed that amount if the nonphysician anesthetist is an anesthesiologist assistant. If the nonphysician anesthetist is a certified registered nurse anesthetist, the total allowed amount can exceed that amount only if unusual circumstances warrant additional payment and those circumstances are documented in the medical record.

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