Ohio Administrative Code

Rule 5160-4-21 Anesthesia services.

Effective: January 1, 2017

(A) Scope and definitions.

(1) This rule sets forth provisions governing payment for the administration or management of anesthesia as a non-institutional professional service rendered by qualified medical practitioners. Provisions governing payment for anesthesia as a dental service are set forth in Chapter 5160-5 of the Administrative Code.

(2) "Base unit" is an anesthesia-related component representing factors other than an anesthetist's time, such as standard pre-operative and post-operative visits, the administration of fluids or blood incident to anesthesia administration, and monitoring.

(3) "Base unit value" is the initial value for a base unit assigned by the American society of anesthesiologists. The society publishes base unit values in its "Relative Value Guide," available at http://www.asahq.org.

(4) "Time unit" is an anesthesia-related component representing the span, reported in minutes, during which an anesthesiologist or a medically-directed or medically-supervised qualified non-physician anesthetist is continuously present. The measured length of the time unit depends on the type of anesthesia.

(a) For neuraxial labor analgesia, the time unit begins when the analgesic is inserted and ends at delivery. Total duration is limited to two hundred forty minutes (four hours).

(b) For all other anesthesia, the time unit begins when the anesthetist starts to prepare the individual for the induction of anesthesia and ends when the presence of the anesthetist is no longer required and the individual may be safely placed under post-anesthetic care.

(5) "Time unit value" is the number of fifteen-minute increments in a time unit, rounded to the

nearest tenth.

(B) Providers.

(1) Rendering providers. The following eligible medicaid providers may administer anesthesia:

(a) An anesthesiologist (i.e., a physician trained in anesthesia);

(b) A certified registered nurse anesthetist (CRNA); or

(c) An anesthesiologist assistant (AA).

(2) Billing providers. The following eligible medicaid providers may receive medicaid payment for submitting a claim for administering anesthesia:

(a) An anesthesiologist;

(b) A CRNA;

(c) A professional medical group; or

(d) An AA.

(C) Coverage.

(1) Payment may be made for the following procedures or activities as anesthesia services:

(a) Procedures performed during a surgical or diagnostic procedure:

(i) Administration of general anesthesia;

(ii) Administration of regional anesthesia;

(iii) Supplementation of local anesthesia;

(iv) Administration of post-operative pain block procedures separately from anesthesia;

(v) Provision of monitored anesthesia care (MAC); and

(vi) Performance of unusual monitoring procedures such as cardiovascular catheterization (e.g., intra-arterial, central venous, Swan-Ganz);

(b) Administration of obstetrical anesthesia for either of two purposes:

(i) Neuraxial analgesia for vaginal delivery (including repeated subarachnoid needle placement, drug injection, and necessary epidural catheter replacement during labor); or

(ii) Anesthesia for cesarean delivery; and

(c) Provision of medical direction or supervision by an anesthesiologist.

(2) No separate payment is made for the following services, which are considered to be part of anesthesia administration:

(a) Routine pre-operative and post-operative visits;

(b) Anesthesia care during the procedure;

(c) The administration of fluid or blood products incident to the anesthesia or surgery; and

(d) Usual monitoring procedures (e.g., electrocardiography, the taking of body temperature, the recording of blood pressure, oximetry, capnography, mass spectometry).

(D) Allowances and limitations.

(1) Payment may be made on a case-by-case basis for two anesthesia services provided to one

individual on a single date of service only if at least one of the following conditions applies:

(a) Between the two surgical or diagnostic procedures, the individual either was released from the recovery area to the floor (or intensive care unit) or was discharged from the hospital;

(b) After completion of the surgical or diagnostic procedure, the individual had to return for a follow-up procedure on an emergency basis;

(c) It was medically necessary for two surgical or diagnostic procedures to be performed separately, and two separate anesthetics were required; or

(d) Anesthesia was administered both for a delivery and separately for a tubal ligation meeting the requirements specified in Chapter 5160-21 of the Administrative Code.

(2) In all other cases, payment may be made only for one anesthesia service provided to one individual on a single date of service.

(3) Payment for anesthesia services may be made to an anesthesiologist only if all of the following conditions are met:

(a) The anesthesiologist acts exclusively as an anesthetist and does not also act as a surgeon or assistant surgeon;

(b) The anesthesiologist completes the following tasks in preparation for anesthesia administration:

(i) Performing a pre-anesthetic examination and evaluation or, for obstetrical anesthesia, performing or approving a pre-anesthetic examination and evaluation for labor analgesia provided by a qualified anesthetist; and

(ii) Prescribing an anesthesia plan or, for obstetrical anesthesia, prescribing or approving an anesthesia plan.

(c) For each individual patient, the anesthesiologist carries out the following activities:

(i) Personally participating in the most demanding parts of the anesthesia plan, including induction and emergence or, for obstetrical anesthesia, personally participating in all critical portions of the procedure (e.g., needle placement for neuraxial analgesia);

(ii) Ensuring that any procedures in the anesthesia plan that the anesthesiologist does not perform are performed by a qualified individual;

(iii) Monitoring the course of anesthesia administration at frequent intervals or, for obstetrical anesthesia, periodically monitoring the course of anesthesia or analgesia administration or ensuring that a qualified anesthetist performs the monitoring;

(iv) Remaining physically present and available for immediate diagnosis and treatment in case of emergency or, for obstetrical anesthesia, remaining readily available for immediate diagnosis and treatment in case of emergency; and

(v) Providing indicated post-anesthetic care.

(4) Payment for medical direction may be made to an anesthesiologist if the anesthesiologist delegates some or all of the activities listed in paragraphs (D)(3)(b) and (D)(3)(c) of this rule to not more than four qualified non-physician anesthetists performing concurrent anesthesia procedures.

(5) Payment for medical supervision may be made to an anesthesiologist if the following conditions are met:

(a) For obstetrical anesthesia, the anesthesiologist delegates some or all of the activities listed in paragraph (D)(3)(c) of this rule to qualified non-physician anesthetists, and the anesthesiologist supervises one of the following activities:

(i) A critical portion of more than four concurrent obstetrical anesthesia procedures (e.g., needle placement for neuraxial analgesia);

(ii) A critical portion of an obstetrical anesthesia procedure along with more than four concurrent

surgical anesthesia procedures; or

(iii) A critical portion of an obstetrical anesthesia procedure while the anesthesiologist is not physically present in the obstetrical suite.

(b) For all other anesthesia, the anesthesiologist delegates some or all of the activities listed in paragraph (D)(3)(c) of this rule to more than four qualified non-physician anesthetists performing concurrent anesthesia procedures.

(6) In addition to payment for surgical procedures, a surgeon or a group practice of surgeons is permitted to receive payment for anesthesia services provided by a CRNA who is employed by the surgeon or group practice.

(7) The services of a CRNA or AA employed by a hospital are considered to be hospital services, payment for which is made to the hospital.

(E) Claim payment.

(1) Payment for an anesthesia service is the lesser of the provider's submitted charge or the medicaid maximum, which is determined by a formula.

(a) The amount is the product of three factors:

(i) The sum of the base unit value and the time unit value;

(ii) The appropriate conversion factor; and

(iii) The relevant multiplier.

(b) Conversion factors and multipliers are listed in the appendix to this rule.

(c) For daily management of epidural or subarachnoid drug administration, the time unit value is zero.

(2) No additional payment will be made on account of physical status, age, body temperature (hypothermia or hyperthermia), emergency conditions, or time of day.