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1.0 Introduction
Florida Medicaid anesthesia services include the management of general anesthesia to render a recipient insensible to pain and emotional stress during medical procedures.

1.1 Florida Medicaid Policies
This policy is intended for use by providers that render anesthesia services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid’s general policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.


1.2 Statewide Medicaid Managed Care Plans
Florida Medicaid managed care plans must comply with the service coverage requirements outlined in this policy, unless otherwise specified in the AHCA contract with the Florida Medicaid managed care plan. The provision of services to recipients enrolled in a Florida Medicaid managed care plan must not be subject to more stringent service coverage limits than specified in Florida Medicaid policies.

1.3 Legal Authority
Anesthesia services are authorized by the following:
- Title XIX of the Social Security Act (SSA)
- Title 42, Code of Federal Regulations (CFR), Parts 440 and 441
- Section 409.905 Florida Statutes (F.S.)

1.4 Definitions
The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid Definitions Coverage Policy.

1.4.1 Claim Reimbursement Policy
A policy document found in Rule Division 59G, F.A.C. that provides instructions on how to bill for services.

1.4.2 Coverage and Limitations Handbook or Coverage Policy
A policy document found in Rule Division 59G, F.A.C. that contains coverage information about a Florida Medicaid service.

1.4.3 General Policies
A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1, F.A.C. containing information that applies to all providers (unless otherwise specified) rendering services to recipients.

1.4.4 Medically Necessary/Medical Necessity
As defined in Rule 59G-1.010, F.A.C.

1.4.5 Provider
The term used to describe any entity, facility, person, or group enrolled with AHCA to furnish services under the Florida Medicaid program in accordance with the provider agreement.

1.4.6 Recipient
For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).
2.0 Eligible Recipient

2.1 General Criteria
An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy.

Provider(s) must verify each recipient’s eligibility each time a service is rendered.

2.2 Who Can Receive
Florida Medicaid recipients requiring medically necessary anesthesia services. Some services may be subject to additional coverage criteria as specified in section 4.0.

2.3 Coinsurance and Copayments
There is no coinsurance or copayment for this service in accordance with section 409.9081, F.S. For more information on copayment and coinsurance requirements and exemptions, please refer to Florida Medicaid’s Copayments and Coinsurance Coverage Policy.

3.0 Eligible Provider

3.1 General Criteria
Providers must meet the qualifications specified in this policy in order to be reimbursed for Florida Medicaid anesthesia services.

3.2 Who Can Provide
Services must be rendered by practitioners licensed in accordance with Chapters 464, 458, or 459, F.S. and working within the scope of their practice.

4.0 Coverage Information

4.1 General Criteria
Florida Medicaid covers services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

4.2 Specific Criteria
Florida Medicaid covers anesthesia services as an adjunct to the following procedures in accordance with the American Medical Association Current Procedural Terminology and the applicable Florida Medicaid fee schedule(s):

- Surgical procedures
- Medical procedures
- Obstetrical procedures
- Dental procedures

4.2.1 Epidural Anesthesia
Up to 360 minutes of epidural anesthesia for a vaginal delivery or a cesarean delivery.

4.2.2 Monitored Anesthesia Care (MAC)
For recipients that the provider anticipates may either:

- Require general anesthesia
- Develop an adverse physiological reaction during the surgical procedure

4.3 Early and Periodic Screening, Diagnosis, and Treatment
As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a
condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid’s Authorization Requirements Coverage Policy.

5.0 Exclusion

5.1 General Non-Covered Criteria
Services related to this policy are not covered when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider’s service

5.2 Specific Non-Covered Criteria
Florida Medicaid does not cover the following as part of this service benefit:

- Services for medical procedures that are not Florida Medicaid compensable
- Telephone communications with recipients, their representatives, caregivers, and other providers, except for services rendered in accordance with Florida Medicaid’s Telemedicine Policy

6.0 Documentation

6.1 General Criteria
For information on general documentation requirements, please refer to Florida Medicaid’s Recordkeeping and Documentation Requirements Coverage Policy.

6.2 Specific Criteria
There is no coverage-specific documentation requirement for this service.

7.0 Authorization

7.1 General Criteria
The authorization information described below is applicable to the fee-for-service delivery system. For more information on general authorization requirements, please refer to Florida Medicaid’s Authorization Requirements Coverage Policy.

7.2 Specific Criteria
Providers must obtain authorization for anesthesia services from the quality improvement organization when indicated on the applicable Florida Medicaid fee schedule(s).

8.0 Reimbursement

8.1 General Criteria
The reimbursement information below is applicable to the fee-for-service delivery system.

8.2 Claim Type
Professional (837P/CMS-1500)

8.3 Billing Code, Modifier, and Billing Unit
Providers must report the most current and appropriate billing code(s), modifier(s), and billing unit(s) for the service rendered, as incorporated by reference in Rule 59G-4.002, F.A.C.
8.3.1 **Billing Code**
Providers must include the appropriate code based on the major procedure performed on the claim form.

Providers must use procedure code 01967 for continuous epidural analgesia during labor and vaginal delivery on the claim form.

Providers must use procedure code 01967 with the service time, and 01968 with one minute of service time if the service progressed to a caesarian delivery.

8.3.2 **Modifier**
Providers must include the following modifiers, as appropriate, on the claim form:

- 78 Unplanned return to the operating room, related procedure
- QK Physician supervision of anesthesia (up to four at one time)
- QS MAC

8.3.3 **Billing Unit**
Providers must include the total anesthesia service time in minutes on the claim form.

8.4 **Diagnosis Code**
Providers must report the most current and appropriate diagnosis code to the highest level of specificity that supports medical necessity, as appropriate for this service.

8.5 **Rate**

8.5.1 **Payment Calculation**
Florida Medicaid calculates reimbursement for services as follows:

The anesthesia base rate is on the Practitioner Fee Schedule, incorporated by reference in Rule 59G-4.002, F.A.C.

8.5.2 **Global Surgery Package**
Florida Medicaid reimbursement includes all necessary services normally furnished by a surgeon before, during, and after a procedure in accordance with the Centers for Medicare and Medicaid Services’ (CMS) global surgery period specifications.


8.5.3 **Enhanced Reimbursement Rate**
Florida Medicaid reimburses pediatric surgery and urological specialty enrolled providers at the enhanced rate when indicated on the fee schedule.