

August 2016

### The Silent 'M' In CMS packs a Big Punch!

Most people think “Medicare” when hearing CMS; however, the Centers for Medicare and Medicaid Services (CMS) also includes administration of Medicaid, the Children’s Health Insurance Program (CHIP), and the Health Insurance Marketplace. You can read more about the Medicare programs in the February 2016 Timely Topic [“The A B C’s \[and D\] of Medicare.”](#) The purpose of this timely topic is to explore some of the challenges affecting anesthesiology in the Medicaid programs.

There are 56 different Medicaid programs, one for each of the 50 states plus American Samoa, District of Columbia, Guam, Northern Marianas Islands, Puerto Rico and the Virgin Islands. Each state administers its own Medicaid program, though the state and federal governments jointly fund it. Each state determines its own criteria for eligibility, provider enrollment process, coverage parameters, clinical and billing requirements, and fee schedules. This information can be significantly different from state to state. If you are a provider of services in multiple states you should know each state’s rules regarding the services you render.

#### The Affordable Care Act and Medicaid Expansion

Medicaid was established in 1966 as part of CMS (then known as the Health Care Financing Administration (HCFA)) under the Department of Health and Human Services to assist with covering medical costs for specific demographics of people with limited income and resources. The most common demographics are children, parents of children, adults with disabilities, and pregnant women. In some cases adults without children, eligible immigrants and seniors may also be eligible for coverage. These categories and corresponding eligibility requirements vary from state to state.

In 2012 CMS released two final rules affecting eligibility and enrollment policies in conjunction with the [Affordable Care Act](#). These rules changed eligibility requirements to create a consistent Medicaid income eligibility level across the country to include all adults (with or without children) with income up to the 133% of the poverty line and significantly increased the number of Americans eligible for Medicaid. In addition, they increased the standard minimum Medicaid benefit package to be equivalent with those benefits now sold on the Affordable Insurance Exchanges. They also temporarily increased federal funding for any newly eligible adults to 100% for a three-year period to help offset the costs of these additional beneficiaries and services. Each state can decide whether it wants to opt in for these expanded eligibility and funding options. At this time 31 states plus the District of Columbia have elected to expand their Medicaid eligibility. Knowing if your [state](#) has

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expanded Medicaid coverage can help you project financials and demographic statistics for your practice.

### **Does Medicaid follow Medicare rules?**

There are significant impacts on anesthesiology billing processes and payments identified in each state's Medicaid coverage and regulations. While there are a few state Medicaid programs that follow Medicare rules, it is more likely that your Medicaid policy mirrors only some, few or even none of the Medicare rules for anesthesiology services and billing guidelines.

Here are some examples of differences among the state Medicaid programs affecting anesthesiology billing:

#### **Medicaid Anesthesia Providers:**

Each Medicaid program has its own provider enrollment criteria and identifies what types of providers may be enrolled as participating providers. While some requirements are mandated by CMS, such as a [revalidation process](#) every five years, other requirements differ from state to state, such as the initial application and review process. As an example, the types of anesthesia providers eligible to be enrolled in Medicaid differ state to state. In most states both a physician anesthesiologist and certified registered nurse anesthetist (CRNA) may be enrolled and can individually bill for anesthesia services. However, in states like Ohio and South Carolina, certified anesthesiologist assistants (C-AA) can also enroll as billable providers. Knowing what types of providers are eligible for enrollment can affect how your care team operates and affect your payment structure.

#### **Medical Direction:**

State Medicaid programs differ in how they allow for and pay (if applicable) medical direction by physician anesthesiologists for other care team providers. Texas allows medical direction. Alaska does not pay for medical direction. Some states allow CRNA payments only if independent but will only pay the supervising physician if the CRNA is employed. Some states like New York allow for medical direction but do not want separate bills for medically directed services and instruct the directed services to be billed by the anesthesiologist without a modifier.

Delaware only allows payment for medical direction of a CRNA if the patient has Medicare as their primary insurance.

Just as there are differences in when and if medical direction is payable, there are also differences in how it is paid. Some states will pay 100% to the performing provider only, whether physician anesthesiologist or CRNA without any variation in fee schedule based on the type of provider. Some states like Florida will allow 20%

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of the anesthesia fee for medical direction in addition to the CRNA's payment. However the CRNA fee schedule is 80% of the physician fee schedule. Many states will cover anesthesiologists and the medically directed CRNAs at 50% each of the total anesthesia fee, some pay at 52.5% to each provider but may have different fee schedules based on the provider's credentials. States like South Carolina pay differing percentages depending on if you are the directing anesthesiologist or the directed CRNA and/or C-AA. Other states, such as Georgia, identify specific conversion factors depending on the modifier used.

#### **Medical Supervision:**

Most states will not pay for supervision of more than four concurrent cases. However, there are some Medicaid programs that will pay. For instance, New York Medicaid will pay three base units to a teaching anesthesiologist for a supervised case, regardless of the procedure, when involved with more than 4 concurrent cases. Ohio will allow payment for medical supervision of a critical component of a labor epidural while also supervising more than four concurrent surgical anesthesia.

#### **Time and base units:**

Most states consider a time unit equal to fifteen minutes; however, there are exceptions. Utah defines a twelve-minute time unit and Alaska uses a ten-minute time unit. Other differences are how a partial unit will be paid. Some will round up to the nearest whole unit (Nevada), some will round a partial time unit down (Florida). Some states will round to the tenth of a unit (Ohio), while some will pay to the minute (Massachusetts).

Base unit values can differ with each state Medicaid program. Some programs use the CMS value (Utah and Nevada) while other states (Mississippi and Alabama) specify that they use ASA base unit values. A couple states have Medicaid specific base units like Virginia. You should also know which year's value will determine payment. As an example, is your program looking at the ASA RVG base unit values for the current year or from 2010?

In a class by itself, Rhode Island pays based on 25% of the surgeon's allowed fee including any cutbacks for additional procedures.

Knowing how your state determines time and base units will help you provide accurate information on your claims and confirm you are receiving appropriate payment for your services.

#### **Conversion factors:**

The states vary widely in pricing anesthesia services. The highest is Alaska's \$42.90 conversion factor; however it only pays that amount for the base units and

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pays a lower conversion factor for time units. The lowest conversion factor is New York at \$10 per unit.

Some state conversion factors vary by modifier (Minnesota, Nebraska). Some have a different conversion factor for time units versus base units like Alaska. Still others such as Wyoming will pay a different specified conversion factor based on the type of provider (physician, CRNA, AA). Many states—but not all—will reduce the total allowed fee for non-physician providers based on a specified percentage (e.g., 75% - Maine, 80% - Florida, 87% - South Carolina, 90% - Connecticut). And, Maryland specifies a different conversion factor for facility versus non-facility anesthesia services.

#### **Labor epidurals:**

Labor epidurals and sometimes other OB anesthesia can be paid by time or set fee depending on the state. Some Medicaid programs limit payment via capped time (max of 360 minutes in Alaska), units (max is 17 units for Arkansas), or with a set fee like Mississippi and Iowa. Others have a different conversion factor (California and Maryland) for OB related anesthesia than what is used for other anesthesia services. Some limit payment for concurrent cases like California, which states no more than 4 units can be billed per hour regardless of how many concurrent cases are performed.

Other issues related to OB anesthesia also change state to state. For example, there are differences in instructions on billing and payment for: standby services, epidurals followed by caesarean delivery and anesthesia, face to face requirements, and add on codes.

#### **Modifiers, Physical Status Modifiers and Qualifying Circumstances:**

Modifier requirements and impacts on fee schedules, units and resulting payment differ widely by state.

Payments for anesthesiology services can be affected by any of these categories individually, or by multiple payment reduction rules working in conjunction with each other if applicable based on the type of service, medical direction, modifiers and type of provider rendering the service. The categories listed above and others identified by your Medicaid program can significantly affect your practice and revenue. It is important to understand each of the payment rules for your state Medicaid program and how it affects your payment.

#### **Where can I find this information for my state Medicaid program?**

Each Medicaid program is responsible for maintaining its own documentation, manuals, policies and procedures, fee schedules and any provider educational materials. Each state

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maintains a state Medicaid website which may house this information. It is important to note that each website is structured differently and the needed information is not identified the same way for each state. Most states will have a provider manual or billing manual that will provide most of the necessary information. Some states have Anesthesiology specific sites or manuals. Some states update their online information as often as quarterly and in a consistent manual. Some states have not updated their manuals in years but may rely instead on provider bulletins, news releases and letters. If you are a new provider in one of these states you cannot rely on just the manuals to get the complete information that may be applicable to your practice. Your state component society may also be able to assist you in making sure you know where to find the most up-to-date information for your state's Medicaid program.

Being familiar with the information on your state Medicaid website and checking the site at least quarterly will help ensure you do not miss important updates or information that will affect your services.

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