TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 1. PHYSICIANS

317:30-5-7. Anesthesia

(a) **Procedure codes.** Anesthesia codes from the Physicians' Current Procedural Terminology should be used. Payment is made only for the major procedure during an operative session.

(b) **Modifiers.** All anesthesia procedure codes must have a modifier. Without the modifier, the claim will be denied.

(c) **Qualifying circumstances.** Certain codes in the Medicine section of the CPT are used to identify extraordinary anesthesia services. The appropriate modifiers should be added to these codes. Additional payment can be made for extremes of age, total body hypothermia, and controlled hypertension.

(d) **Hypothermia.** Hypothermia total body or regional is not covered unless medical necessity is documented and approved through review by ~~the Authority's~~ OHCA's Medical Consultants.

(e) **Anesthesia with Blood Gas Analysis**. Blood gas analysis is part of anesthesia service. Payment for anesthesia includes payment for blood gas analysis.

(f) **Steroid injections.** Steroid injections administered by an anesthesiologist are covered as nerve block. The appropriate CPT procedure code is used to bill services.

(g) **Local anesthesia**. If local anesthesia is administered by attending surgeon, payment is included in the global surgery fee, except for spinal or epidural anesthesia in conjunction with childbirth.

(h) **Stand by anesthesia**. This is not covered unless the physician is actually in the operating room administering medication, etc. If this is indicated, claim will be processed as if anesthesia was given. Use appropriate anesthesia code.

(i) **Other qualifying circumstances.** All other qualifying circumstances, i.e., physical status, emergency, etc. have been structured into the total allowable for the procedure.

(j) **Central venous catheter and anesthesia.** Payment for placement of central venous catheter, injection of anesthesia substance or similar procedures will be made only when the procedure is distinctly separate from the anesthesia procedure.

(k) **Pain management.** Payment for pain management procedures performed during the anesthesia session will be

made when it is medically necessary, it is submitted with appropriate documentation, and it is submitted with the appropriate modifier(s).

PART 69. CERTIFIED REGISTERED NURSE ANESTHETISTS

317:30-5-607. Billing instructions

The CRNA is responsible for entering the correct anesthesia procedure code on the appropriate claim form. Anesthesia codes from the Physicians' Current Procedural Terminology or Medicare assigned codes should be used.

(1) Payment is made only for the major procedure during an operative session.

(2) All anesthesia procedure codes must have a modifier. Without the modifier, the claim will be denied. Payment to the CRNA is limited to 80% of the physician allowable for anesthesia services without medical direction using modifier QZ and 50% of the physician allowable when services are provided under the medical direction of an anesthesiologist using modifier QX.

(3) Certain codes in the Medicine section of the CPT are used to identify extraordinary anesthesia services. Additional payment can be made when applicable for extremes of age, total body hypothermia and controlled hypertension.

(4) All other qualifying circumstances, i.e., physical status, emergency, etc., have been structured into the total allowable for the procedure.

(5) Hypothermia total body or regional is not covered unless medical necessity is documented and approved through review by ~~the Authority's~~ OHCA's Medical Consultants.

(6) Payment for placement of central venous catheter, injection of anesthesia substance or similar procedures will be made only when the procedure is distinctly separate from the anesthesia procedure.

(7) Payment for pain management procedures performed during the anesthesia session will be made when it is medically necessary, it is submitted with appropriate documentation, and it is submitted with the appropriate modifier(s).

PART 70. ANESTHESIOLOGIST ASSISTANTS

317:30-5-614. Billing instructions

The AA is responsible for entering the correct anesthesia procedure code on the appropriate claim form. Anesthesia

codes from the Physicians' Current Procedural Terminology or Medicare assigned codes should be used.

(1) Payment is made only for the major procedure during an operative session.

(2) All anesthesia procedure codes must have a modifier. Without the modifier, the claim will be denied. Payment is made to an AA for services provided under the direct supervision of a licensed anesthesiologist and is limited to 50% of the physician allowable using modifier QX.

(3) Certain codes in the Medicine section of the CPT are used to identify extraordinary anesthesia services. Additional payment can be made when applicable for extremes of age, total body hypothermia and controlled hypertension.

(4) All other qualifying circumstances, i.e., physical status, emergency, etc., have been structured into the total allowable for the procedure.

(5) Hypothermia total body or regional is not covered unless medical necessity is documented and approved through review by ~~the Authority's~~ OHCA's Medical Consultants.

(6) Payment for placement of central venous catheter, injection of anesthesia substance or similar procedures will be made only when the procedure is distinctly separate from the anesthesia procedure.

(7) Payment for pain management procedures performed during the anesthesia session will be made when it is medically necessary, it is submitted with appropriate documentation, and it is submitted with the appropriate modifier(s).