Fee Schedule Guidelines

Anesthesia

WSI

North Dakota Workforce Safety & Insurance

January 2024

Notice

The five character numeric codes included in the North Dakota Fee Schedule are obtained from Current Procedural Terminology (CPT®), copyright 2023 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physicians. The five character alphanumeric codes included in the North Dakota Fee Schedule are obtained from HCPCS Level II, copyright 2023 by Optum360, LLC. HCPCS Level II codes are maintained jointly by The Centers for Medicare and Medicaid Services (CMS), the Blue Cross and Blue Shield Association (BCBSA), and the Health Insurance Association of America (HIAA).

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The WSI Fee Schedule is not a guarantee of payment. The fact that WSI assigns a procedure or service a HCPCS code and a payment rate does not imply coverage by WSI but indicates the maximum allowable payment for approved services. Services represented are subject to provisions of WSI including: compensability, claim payment logic, applicable medical policy, benefit limitations and exclusions, bundling logic, and licensing scope of practice limitations.

Any changes made to Pricing Methodology are subject to the North Dakota Public Hearing process. WSI reserves the right to implement changes to the Payment Parameters, Billing Requirements, and Reimbursement Procedures as needed. WSI incorporates all applicable changes into the relevant Fee Schedule Guideline at the time of implementation, and communicates these changes in Medical Providers News, available on the WSI website at www.workforcesafety.com/news/medical-providers. WSI reviews and updates all Fee Schedule rates on an annual basis, with additional updates made on a quarterly basis when applicable.

For reference purposes, the sections of the North Dakota Administrative Code (N.D.A.C.) that regulate medical services are **92-01-02-27 through 92-01-02-46**. The complete N.D.A.C. is accessible on the North Dakota Legislative Council website: http://www.legis.nd.gov/agency-rules/north-dakota-administrative-code.

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Anesthesia Pricing Methodology

Anesthesia Pricing Methodology outlines the methods used by Workforce Safety & Insurance (WSI) to determine the final rates represented on the Anesthesia Fee Schedule. The Anesthesia Fee Schedule uses the procedure codes and descriptions as defined by the Healthcare Common Procedure Coding System (HCPCS), their respective payment status indicators, and payment amounts. In accordance with North Dakota Administrative Code 92-01-02-29.2, any provider who renders treatment to a claimant under the jurisdiction of WSI is reimbursed according to the rates assigned in the Anesthesia Fee Schedule. A provider may access the complete Anesthesia Fee Schedule and other resources referenced within this document by visiting the Medical Provider section of the WSI website: www.workforcesafety.com.

Status Indicators

WSI assigns one of the following status indicators to each HCPCS code within the Anesthesia Fee Schedule:

Indicator	Description	Pricing Methodology
A	Active Code	Service is payable under the applicable WSI Fee Schedule.
B	Packaged Code	Service is not separately payable. Payment is packaged into the payment for another service.
C	Custom Priced Code	Service is payable using usual and customary or WSI-negotiated rates.
D	Discontinued Code	Service is not payable. Code was discontinued effective beginning of the calendar year.
P	Excluded Code	Service is not payable under the WSI Fee Schedule.

Calculation of the Reimbursement Rate

For HCPCS codes assigned a status code ‘A’, WSI applies the following formula to determine the maximum allowable reimbursement rate:

$$\left(\text{Base Relative Value Units (RVU)} + \text{Time Units} + \text{Physical Status Modifier Units}\right) \times \text{Conversion Factor} = \text{Maximum Allowable Reimbursement Rate}$$

For 2024, the Conversion Factor is $74.12.

The Base Relative Value Unit (RVU) is the value assigned by The American Society of Anesthesiologists.

Annual Updates

WSI updates the Anesthesia Conversion Factor by the same percentage as the WSI Medical Provider Conversion Factor.

Limitations of the Anesthesia Fee Schedule

The payment rates listed on the Anesthesia Fee Schedule indicate the maximum allowable payment for approved services only. The fact that a procedure or service is assigned a HCPCS code and a payment rate does not imply coverage by WSI but indicates the maximum allowable payment for approved services. The final payment rate may be impacted by the payment parameters and billing requirements enforced by WSI. A provider is encouraged to carefully review WSI's Payment Parameters, Billing Requirements, and Reimbursement Procedures to avoid unneccesary delays and denials of payment.

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Anesthesia Payment Parameters

Anesthesia Payment Parameters outline the rules for payment adopted by WSI. While WSI has adopted many of Medicare's rules for payment, WSI has developed a set of unique rules that are applied to the final payment of approved services. The complete payment parameters enforced by WSI are as follows:

Advanced Beneficiary Notice (ABN) – A provider may utilize the ABN form to notify an injured employee of the costs associated with a recommended procedure that is: statutorily excluded from coverage, statutorily limited in quantity, deemed by WSI as not medically necessary to treat the work injury. To identify a charge accompanied with a signed ABN, a provider should append modifier GA to each applicable bill line. A provider should then submit the signed ABN along with the bill and medical documentation to WSI.

Authorization – Authorization for an anesthesia services falls under the authorization of the surgical procedure. A separate authorization is not required; however, anesthesia provided for a surgical procedure denied for no prior authorization will also be denied for no prior authorization. To verify prior authorization, contact the Utilization Review department at 888-777-5871.

"Lesser of" Payments" – The rates listed on the Anesthesia Fee Schedule represent the maximum amount payable for services rendered. WSI pays the "lesser of" the billed charge or the Fee Schedule amount. This is done at the line level rather than the bill level.

Modifiers – WSI modifies the maximum allowable reimbursement rate for anesthesia services based on anesthesia claim and physical status modifiers as follows:

Anesthesia Claim Modifiers

Modifier	Description	Rate
AA	MDA personally performs a case	100%
QY	MDA medically directs 1 CRNA	50%
QK	MDA medically directs 2 – 4 CRNAs	50%
AD	MDA medically supervises more than 4 concurrent anesthesia procedures	**
QX	CRNA performs case with medical direction	50%
QZ	CRNA performs case without medical direction	100%

**WSI limits the RVU used in the reimbursement rate to 3. Time units are excluded from the reimbursement rate; however a MDA may request the inclusion of 1 time unit into the reimbursement rate by submitting the Medical Bill Appeal (M6) form with medical documentation, which supports their presence at induction.

Physical Status Modifiers

Modifier	Description	Units Payable
P1	A normal healthy patient	0
P2	A patient with mild systemic disease	0
P3	A patient with severe systemic disease	1
P4	A patient with severe systemic disease that is a constant threat to life	2
P5	A moribund patient who is not expected to survive without the operation	3
P6	A declared brain-dead patient whose organs are being removed for donor purposes	0

NCCI Edits – WSI incorporates all applicable NCCI edits.

Non-Anesthesia Services – WSI pays for non-anesthesia medical services (e.g., insertion of catheters, placement of central venous and arterial lines, intubations, pain management, etc.) under the WSI Medical Provider Fee Schedule.

Qualifying Circumstances – In the event an anesthesiologist must provide anesthesia under particularly difficult circumstances, a provider may report a single unit of the relevant qualifying circumstances code in addition to the anesthesia service code(s). WSI will reimburse for a qualifying circumstance to either an anesthesiologist, who supervises or personally performs the procedure, or a CRNA, who performs the procedure without medical direction. A CRNA who performs a qualifying circumstance procedure under the medical direction of an anesthesiologist is not eligible for additional reimbursement. WSI reimburses for a qualifying circumstance per the Medical Provider Fee Schedule as follows:

Code	Code Description	Base Units
99100	Anesthesia for a patient of extreme age; under 1 year and over 70	1
99116	Anesthesia complicated by utilization of total body hypothermia	5
99135	Anesthesia complicated by utilization of controlled hypotension	5
99140	Anesthesia complicated by emergency* conditions.	2

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Anesthesia Billing Requirements

Anesthesia Billing Requirements outline the rules for billing adopted by WSI. WSI returns or denies inappropriately submitted bills. WSI notifies a provider of inappropriately submitted bills via a return letter or remittance advice. A provider must correct any returned bills prior to resubmission.

Bill Forms – A provider must submit medical bills for anesthesia services on a standard CMS-1500 form, UB-04 form, or via EDI.

Bill Form Submission – WSI offers the following options for bill submission:

Electronic Billing – A provider submitting more than 50 bills per year to WSI must send charges electronically through Carisk Intelligent Clearinghouse. This option allows for the electronic submission of professional (837p) and institutional (837i) charges along with supporting medical documentation. Contact Carisk at 888-238-4792 for additional information.

Paper Billing – A provider submitting less than 50 bills per year to WSI may send charges in red and white paper format with supporting medical documentation at the following address:

Workforce Safety & Insurance
PO Box 5585
Bismarck, ND 58506

Coding – A provider must bill using only current and appropriate CPT codes for anesthesia services.

Medical Direction Criteria – WSI requires an MDA filing a bill for the medical direction of a CRNA to meet the following Medical Direction criteria, as required by Medicare:

- Perform a pre-anesthetic examination and evaluation;
- Prescribe the anesthesia plan;
- Personally participate in the most demanding procedures in the anesthesia plan, including, if applicable, induction and emergence;
- Ensure any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist;
- Monitor the course of anesthesia administration at frequent intervals;
- Remain physically present and available for immediate diagnosis and treatment of emergencies; and
- Provide indicated post-anesthesia care

Medical Documentation – A provider must submit medical documentation to support all billed charges. WSI's Documentation Policies are available for detailed information on documentation requirements.

Medical Necessity – A provider must bill using the same medical necessity guidelines used for Medicare.

Modifiers – WSI's policy on the use of anesthesia modifiers is as follows:

- **Payment Modifiers** – WSI requires the use of a payment modifier (AA, AD, QK, QX, QY or QZ) and will return a bill submitted without it. These modifiers must be in the first modifier position on the bill.
- **Physical Status Modifiers** – When appropriate, a provider may submit a physical status modifier (P1, P2, P3, P4, P5 or P6). These modifiers must be in the second modifier position on the bill.

National Provider Identification (NPI) – WSI requires entities who are eligible for NPI to be registered with National Plan & Provider Enumeration System. When applicable, WSI requires a provider to include the NPI at both the rendering provider and billing provider levels.

Non-Anesthesia Services – A provider should bill non-anesthesia services (e.g., insertion of catheters, placement of central venous and arterial lines, intubations, pain management services) as a single unit and omit anesthesia payment or patient status modifiers.

Timely Filing – A provider must submit bills to WSI within 365 days of the date of service.

Units – A provider must bill the actual number of anesthesia minutes as the number of units on the CMS-1500. WSI calculates the number of time units used in the calculation of the maximum allowable reimbursement rate based on the number of billed minutes.

Unusual Circumstances – Under the unusual circumstances in which it is medically necessary for both the CRNA and the anesthesiologist to be completely and fully involved during a procedure, a provider should bill the charges with an 'AA' modifier for the physician charges and a 'QZ' modifier for the CRNA charges. In such circumstances, the provider must submit adequate documentation to support payment of the full fee for each provider.

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Anesthesia Reimbursement Procedures

Anesthesia Reimbursement Procedures outline how WSI communicates bill processing information and issues payment to a medical provider. In addition, it outlines WSI's requirements for reimbursement. A provider is encouraged to follow WSI Reimbursement Procedures to prevent delays in the payment processing of medical charges submitted to WSI.

Provider Registration – Prior to reimbursement for treatment, a provider is required to register the applicable Billing NPIs with WSI by completing the Medical Provider Payee Registration form. For additional information, visit the Provider Registration section of WSI's website.

Payment Address – WSI issues payment to the Pay-to Address registered on the Medical Provider Payee Registration form, regardless of the address submitted on the bill form. To update a payment address, a provider must resubmit the registration form for each applicable Billing NPI.

Remittance Advice – WSI issues remittance advices for processed medical bills each Friday. The remittance advice includes important information about a medical charge, including: patient name, date of service, procedure billed, billed amount, paid amount, and remittance advice reason codes. A provider should refer to the How to Read the WSI Remittance Advice document for assistance with interpretation of the remittance advice. This reference includes a sample remittance advice, along with definitions for significant fields within the remittance advice. Contact customer service at 1-800-777-5033 with questions or to obtain a duplicate remittance advice.

> **Reason Codes** – The WSI Remittance Advice Reason Codes document provides a comprehensive listing and description of the reason codes utilized by WSI. Each reason code identifies a cause for the adjudication of a medical charge and specifies whether a provider may bill a patient. When a reason code specifies a provider may bill a patient, WSI sends a "Notice of Non-Payment" letter to the patient informing them of their responsibility for the charge. In accordance with North Dakota Administrative Code 92-01-02-45.1, if a reason code does not state that a provider may bill a patient, the provider cannot bill the charge for the reduced or denied service to the patient, the employer, or another insurer.
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> **Bill Status Inquiries** – Bill status information is available 24/7 via myWSI. The Provider Bill Status application permits a registered user to view bill receipt status and processing details as well as export results. For access, a practice must submit a myWSI Portal Registration (M14) form for each group/billing NPI. With the availability of this resource, a provider or their TPA will not need to contact WSI via phone or email to inquire on the status of a billed charge.

Overpayments – When an overpayment occurs on a medical bill, WSI will notify the provider of the overpayment in a letter. WSI allows 30 days from the date of the letter for a provider to issue the requested refund. If a provider does not issue the refund within 30 days of the date of the letter, WSI will withhold the overpayment from future payments.

Medical Services Disputes – North Dakota Administrative Code 92-01-02-46 provides the procedures followed for managed care disputes. A provider who wishes to dispute a denial or reduction of a service charge must submit the Medical Bill Appeal (M6) form, along with supporting documentation, within 30 days of the remittance advice issue date. WSI will not address a provider dispute submitted without the M6 form.

1600 E Century Ave, Suite 1
PO Box 5585
Bismarck, ND 58506-5585
701-328-3800
800-777-5033
Fax: 701-328-3820

www.workforcesafety.com