ANESTHESIA SERVICES

ELIGIBLE PROVIDERS

In order to receive payment, all eligible servicing and billing provider's National Provider Identifiers (NPI) must be enrolled with South Dakota Medicaid. Servicing providers acting as a locum tenens provider must enroll in South Dakota Medicaid and be listed on the claim form. Please refer to the provider enrollment chart for additional details on enrollment eligibility and supporting documentation requirements.

South Dakota Medicaid has a streamlined enrollment process for eligible ordering, referring, and attending providers that may require no action on the part of the provider as submission of claims constitutes agreement to the South Dakota Medicaid Provider Agreement.

Services may be provided by the following enrolled providers:

- Anesthesiologists or other physicians;
- Dentists or oral surgeons; and
- Certified Registered Nurse Anesthetists.

South Dakota Medicaid does not cover anesthesia services provided by assistants including supervision of services provided by these individuals.

ELIGIBLE RECIPIENTS

Providers are responsible for checking a recipient's Medicaid ID card and verifying eligibility before providing services. Eligibility can be verified using South Dakota Medicaid's online portal.

The following recipients are eligible for medically necessary services covered in accordance with the limitations described in this chapter:

Coverage Type	Coverage Limitations
Medicaid/CHIP Full Coverage	Medically necessary services covered in accordance with the limitations described in this chapter.
Qualified Medicare Beneficiary – Coverage Limited (73)	Coverage restricted to copays, coinsurance, and deductibles on Medicare A and B covered services.
Unborn Children Prenatal Care Program (79)	Coverage restricted to pregnancy related services only including medical issues that can harm the life of the mother or baby.
Medicaid Renal Coverage up to $5,000 (80)	Coverage restricted to outpatient dialysis, home dialysis, including supplies, equipment, and special water softeners, hospitalization related to

	renal failure, prescription drugs necessary for dialysis or transplants not covered by other sources and non-emergency medical travel reimbursement to renal failure related appointments.

Refer to the Recipient Eligibility manual for additional information regarding eligibility including information regarding limited coverage aid categories.

COVERED SERVICES AND LIMITS

General Coverage Principles
Providers should refer to the General Coverage Principles manual for basic coverage requirements all services must meet. These coverage requirements include:

- The provider must be properly enrolled;
- Services must be medically necessary;
- The recipient must be eligible; and
- If applicable, the service must be prior authorized.

The manual also includes non-discrimination requirements providers must abide by.

Anesthesia Coverage
Anesthesia services are covered for recipients undergoing surgical or nonsurgical procedures in an outpatient or inpatient setting where the administration of an anesthetic is required. To provide the care deemed appropriate, the type of anesthesia may be any of the following:

- General anesthesia;
- Regional anesthesia;
- Topical or local anesthesia;
- Monitored anesthesia care; and
- Moderate sedation.

Global Service
Anesthesia is a global service and includes the following:

- Preoperative and postoperative visits;
- Anesthesia care during the procedure;
- Administration of fluids or blood; and
- Usual monitoring services (ECG, temperature, blood pressure, oximetry, capnography and mass spectrometry).

Unusual forms of monitoring such as placement of intra-arterial and central venous lines and insertion of Swan-Ganz catheters are not included in the global payment and are separately covered for anesthesiologists and CRNAs.

Preanesthetic Evaluations and Postoperative Visits
South Dakota Medicaid uses the Centers for Medicare & Medicaid Services (CMS) list of base units, adopted from the relative base units established by the American Society of Anesthesiologists (ASA). The base units for anesthesia services includes usual preoperative and postoperative visits. No separate payment is allowed for the preanesthetic evaluation regardless of when it occurs unless the recipient is not induced with anesthesia because the surgery was cancelled.

If an anesthetic is not administered due to a surgery cancellation, the anesthesiologist or independent CRNA may bill an Evaluation and Management (E/M) CPT code that demonstrates the level of service performed.

Multiple Anesthesiologists
When multiple anesthesiologists provide services, the anesthesiologist who either started the case or who spent the most time with the recipient providing services must submit a claim for the entire case. The time for all anesthesia procedures must be combined and the documentation must include all physicians involved.

Medical Direction
Anesthesiologists can be reimbursed for the personal medical direction, as distinguished from supervision, they furnish to CRNAs. In all cases where the anesthesiologist provides medical direction, he or she must be physically present in the operating suite. Medical direction is a billing distinction describing a higher level of physician involvement than medical supervision. South Dakota Medicaid will cover medical direction services when the anesthesiologist directs CRNAs in two, three, or four concurrent cases and personally performs the following:

- Pre-anesthetic exam and evaluation;
- Prescribes anesthesia plan;
- Personally participates in anesthesia procedures; including induction and emergence;
- Ensures procedures in anesthesia plan that he/she does not perform are performed by qualified anesthetist;
- Monitors course of anesthesia frequently;
- Remains physically present and available for immediate diagnosis and treatment of emergencies; and
- Provides any indicated post-anesthesia care.

If anesthesiologists are in a group practice, one physician member may provide the pre-anesthetic exam and evaluation, and another may fulfill the other criteria. Similarly, one physician member of the group may provide post-anesthesia care, while another member of the group provides the other components of anesthesia services. The medical record must identify the physicians who rendered the services.

Teaching
Teaching occurs when the anesthesiologist is training residents in up to two concurrent cases or training a resident in one case, while medically directing in another case. The anesthesiologist must document his/her presence during the key and critical portions of the service and the resident append the GC modifier (service performed in part by a resident under direction of a teaching physician) following the anesthesia modifier. A physician's presence during only the pre-and post-operative care is not sufficient to receive Medicaid payment. The teaching physician must be immediately available if needed to furnish anesthesia during the entire procedure.

Medical Supervision
Medical supervision occurs when the anesthesiologist is involved in more than four concurrent cases and when not all medical direction listed above are performed.

Anesthesia for Dental Services
Effective for claims with dates of service on or after July 1, 2025, anesthesiologists or CRNAs that provide anesthesia services in a dental office must submit the claim to the dental vendor on an ADA claim form rather than to South Dakota Medicaid on a CMS 1500 or via an 837P electronic transaction. Services must be rendered in compliance with applicable requirements in ARSD Ch. 20:43:09. Services must be billed using the following codes:

- D9222 - Administration of deep sedation/general anesthesia – first 15-minute increment, or any portion thereof
- D9223 - Administration of Deep sedation/general anesthesia – each subsequent 15-minute increment or any portion thereof
- D9224 - Administration of general anesthesia with advanced airway – first 15-minute increment or any portion thereof. Effective January 1, 2026.
- D9225 - Administration of general anesthesia with advanced airway – each subsequent 15-minute increment or any increment thereof. Effective January 1, 2026.
- D9239 - Administration of moderate sedation intravenous – first 15-minute increment or any portion thereof
- D9243 - Administration of moderate sedation intravenous – each subsequent 15-minute increment or any portion thereof

Effective for dates of services on or after July 1, 2025, reimbursement is limited to a maximum of $1,500 per date of service. Refer to the Children and Adult Dental Provider Manuals for information regarding dental anesthesia.

NON-COVERED SERVICES

General Non-Covered Services
Providers should refer to ARSD 67:16:01:08 or the General Coverage Principles manual for a general list of services that are not covered by South Dakota Medicaid.

Non-Covered Anesthesia Services
South Dakota Medicaid does not cover the following services:

- Anesthesia administered in association with a non-covered procedure;
- Qualifying circumstance CPT codes 99100, 99116, 99135, and 99140; and
- Supervision or medical direction provided by a physician who is not an anesthesiologist.

South Dakota Medicaid does not separately pay for anesthesia for a medical or surgical procedure when it is provided by the practitioner performing the procedure with the exception of moderate conscious sedation.

Documentation Requirements

General Requirements
Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to South Dakota Medicaid. These records must be retained for at least 6 years after the last date a claim was paid or denied. Please refer to the Documentation and Record Keeping manual for additional requirements.

Reimbursement and Claim Instructions

Timely Filing
South Dakota Medicaid must receive a provider's completed claim form within 6 months following the month the service was provided. Requests for reconsiderations will only be considered if they are received within the timely filing period or within 3 months of the date a claim was denied. The time limit may be waived or extended by South Dakota Medicaid in certain circumstances. Providers should refer to the General Claim Guidance manual for additional information.

Third-Party Liability
Medicaid recipients may have one or more additional source of coverage for health services. South Dakota Medicaid is generally the payer of last resort. Providers must pursue the availability of third-party payment sources and should use the Medicare Crossover or Third-Party Liability billing instructions when applicable. Providers should refer to the General Claim Guidance manual for additional information.

Reimbursement
Conversion Factor and Fee Schedules
Anesthesia services in CPT code range 00100 – 01996 provided by a physician or a CRNA are reimbursed utilizing the conversion factor. Payment will be the lower of the provider's usual and customary charge or the amount established on Anesthesia Services fee schedule. Effective July 1, 2024, the anesthesia conversion factor will be reimbursed at 100% of Medicare's established rate. The rate will be rebased annually on January 1. Anesthesia services outside the CPT code range 00100 – 01996 are paid based on the fee listed on the Physician Services fee schedule.

Modifiers
Anesthesia modifiers AD, QK, QX, and QY have the following effect:

- For the period of July 1, 2024 to June 30, 2025 the payment effect will be 75% of the allowable amount.
- For the period of July 1, 2025 or later the payment effect will be 50%.

Time Units

Time must be reported in 15-minute units beginning from the time the physician or a CRNA begins to prepare the patient for induction of anesthesia in the operating room (or in an equivalent area) and ends when the anesthesiologist is no longer in personal attendance and the recipient may be safely placed under postoperative supervision. Units must be reported in whole numbers. If a partial 15-minute unit occurred, only report that unit on the claim if it was 8 minutes or more.

Base Units

Do not include base units on the claim. South Dakota Medicaid's claims processing system determines the number of base units.

Reimbursement Calculation

The formula for reimbursement of CPT code range 00100 -01999 is the following:
(Time Units + Base Units) X Conversion Factor.

The payment amount is the lesser of the provider's usual and customary amount or the reimbursement calculation. Services provided by a nurse anesthetist are reimbursed at the same rate as services provided by a physician.

Dental Services

Payment for dental anesthesia services is limited to the lesser of the provider's usual and customary charge or the fee contained on South Dakota Medicaid's Dental Services fee schedules.

Claim Instructions

Claims for professional services including inpatient and outpatient professional services must be submitted on a CMS 1500 claim form or 837P. Detailed claim form instructions are available on our website. A claim submitted for the services of a physician or other licensed practitioner must be for services provided by the physician or other licensed practitioner or an employee who is under the direct supervision of the practitioner.

Start and End Time

The start and end time must be reported on the claim form. The start and end time can either be listed in the shaded portion of box 24 or in box 19. Failure to report start and end time may result in the claim being denied.

Unlisted Service or Procedure

A service or procedure that is provided that is not listed in the CPT codebook may be reported using CPT code 01999. This code pends for review by South Dakota Medicaid. Providers must submit supporting documentation with the claim including an adequate definition or description of the nature, extent, and need for the procedure and the time effort, and equipment necessary to provide the service.

Modifiers

Claims must include any relevant modifying circumstance of the services or procedure by adding the applicable modifier code to the procedure code. Refer to our authorized modifiers document for additional information.

Nurse Anesthetist

Anesthesia services provide by a nurse anesthetist must be billed on a CMS 1500 claim form or an 837P. CRNA-rendered services are billed under the CRNA's National Provider Identifier (NPI) and the appropriate procedure code modifier must be used to identify that the service was rendered by a CRNA:

- QX – CRNA service: with medical direction by a physician
- QZ – CRNA service: without medical direction by a physician

Hospital employed nurse anesthetist services are reimbursed as part of an in-state outpatient hospital's payment unless the hospital is reimbursed under the APC reimbursement methodology. Hospital employed CRNA services are also included in the payment for in-state inpatient hospital services with the exception of services reimbursed via the DRG reimbursement methodology. CRNA's may bill separately if the hospital is being reimbursed under the APC or DRG reimbursement methodology. Reimbursement for CRNA services for out-of-state outpatient and inpatient hospitals is included in the hospital's reimbursement. The services are not separately billable.

REFERENCES

- Administrative Rule of South Dakota (ARSD)
- South Dakota Medicaid State Plan
- Code of Federal Regulations

QUICK ANSWERS

1. **Are Anesthesia services exempt from needing a prior authorization for out of state services?**

   No, anesthesia services do not require their own prior authorization but must include the prior authorization number associated with the authorized surgical service.

2. **How do I report time on the claim form?**

   Time must be reported in 15-minute units beginning from the time the physician or a CRNA begins to prepare the patient for induction of anesthesia and ends when the anesthesiologist is no longer in personal attendance. Units must be reported in whole numbers. If a partial 15-minute unit occurred, only report that unit on the claim if it was 8 minutes or more.