WAC 182-531-0300 Anesthesia providers and covered physician-related services. The medicaid agency bases coverage of anesthesia services on medicare policies and the following rules:

(1) The agency reimburses providers for covered anesthesia services performed by:

(a) Anesthesiologists;

(b) A doctor of medicine or osteopathy (other than an anesthesiologist);

(c) Certified registered nurse anesthetists (CRNAs);

(d) Oral surgeons with a special agreement with the agency to provide anesthesia services; and

(e) Other providers who have a special agreement with the agency to provide anesthesia services.

(2) The agency covers and reimburses anesthesia services for children and noncooperative clients in those situations where the medically necessary procedure cannot be performed if the client is not anesthetized. A statement of the client-specific reasons why the procedure could not be performed without specific anesthesia services must be kept in the client's medical record. Examples of such procedures include:

(a) Computerized tomography (CT);

(b) Dental procedures;

(c) Electroconvulsive therapy; and

(d) Magnetic resonance imaging (MRI).

(3) The agency covers anesthesia services provided for any of the following:

(a) Dental restorations and/or extractions:

(b) Maternity per subsection (9) of this section. See WAC 182-531-1550 for information about sterilization/hysterectomy anesthesia;

(c) Pain management per subsection (5) of this section;

(d) Radiological services as listed in WAC 182-531-1450; and

(e) Surgical procedures.

(4) For each client, the anesthesiologist provider must do all of the following:

(a) Perform a preanesthetic examination and evaluation;

(b) Prescribe the anesthesia plan;

(c) Personally participate in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence;

(d) Ensure that any procedures in the anesthesia plan that the provider does not perform, are performed by a qualified individual as defined in the program operating instructions;

(e) At frequent intervals, monitor the course of anesthesia during administration;

(f) Remain physically present and available for immediate diagnosis and treatment of emergencies; and

(g) Provide indicated post anesthesia care.

(5) The agency does not allow the anesthesiologist provider to:

(a) Direct more than four anesthesia services concurrently; and

(b) Perform any other services while directing the single or concurrent services, other than attending to medical emergencies and other limited services as allowed by medicare instructions.

(6) The agency requires the anesthesiologist provider to document in the client's medical record that the medical direction requirements were met.

(7) General anesthesia:

(a) When a provider performs multiple operative procedures for the same client at the same time, the agency reimburses the base anesthesia units (BAU) for the major procedure only.

(b) The agency does not reimburse the attending surgeon for anesthesia services.

(c) When more than one anesthesia provider is present on a case, the agency reimburses as follows:

(i) The supervisory anesthesiologist and certified registered nurse anesthetist (CRNA) each receive 50 percent of the allowed amount.

(ii) For anesthesia provided by a team, the agency limits reimbursement to 100 percent of the total allowed reimbursement for the service.

(8) Pain management:

(a) The agency pays CRNAs or anesthesiologists for pain management services.

(b) The agency allows two postoperative or pain management epidurals per client, per hospital stay plus the two associated E&M fees for pain management.

(9) Maternity anesthesia:

(a) To determine total time for obstetric epidural anesthesia during normal labor and delivery and c-sections, time begins with insertion and ends with removal for a maximum of six hours. "Delivery" includes labor for single or multiple births, and/or cesarean section delivery.

(b) The agency does not apply the six-hour limit for anesthesia to procedures performed as a result of post-delivery complications.

(c) See WAC 182-531-1550 for information on anesthesia services during a delivery with sterilization.

(d) See chapter 182-533 WAC for more information about maternity-related services.

[Statutory Authority: RCW 41.05.021, 41.05.160, and 42 C.F.R. § 482.52. WSR 22-16-037, § 182-531-0300, filed 7/27/22, effective 8/27/22. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 17-04-039, § 182-531-0300, filed 1/25/17, effective 2/25/17. WSR 11-14-075, recodified as § 182-531-0300, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-531-0300, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.520. WSR 01-01-012, § 388-531-0300, filed 12/6/00, effective 1/6/01.]