- 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 ${\tt E\&M}$ 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.]