Anesthesia Services

Policy

The following provider types can bill for anesthesia services:

- Hospital, Outpatient (provider type 12)
- Physician, M.D., Osteopath, D.O. (provider type 20)
- Certified RN Practitioner (provider type 24)
- Nurse Anesthetists (provider type 72)
- Physician's Assistant (provider type 77)

State policy specific to anesthesia services is in Medicaid Services Manual, Chapter 600, Section 603. This policy covers base units, reportable anesthesia time and appropriate billing.

Covered services and rates

Covered services and rates are listed on the Nevada Medicaid website (select Resources, then Rates, then scroll down and click Anesthesiology Unit Values).

Prior authorization

Anesthesia itself does not require prior authorization; however, prior authorization may be required for the related surgical procedure or service.

Time-based billing

Professional claims submitted for anesthesia services must be submitted with a value in minutes. Actual time must be submitted instead of units. For example, if the service is rendered in 128 minutes, submit the claim with 128 minutes.

Obstetric Anesthesia Codes Payment Methodology

Attention provider types 12, 20, 24, 72 and 77: The payment methodology for the following obstetric anesthesia procedure codes has been updated to reimburse providers using an occurrence-based rate. Providers are instructed to bill these codes as an occurrence-based service: one unit for the occurrence and no time-based units.

The impacted Current Procedural Terminology (CPT) codes are:

Procedure Code	Procedure Code Description
01967	Neuraxial labor analgesia/anesthesia for planned vaginal delivery
01968	Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia
01969	Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia