Anesthesia providers billing for maternity procedures should follow the following directions:

**DELEIVERING PHYSICIAN**

62311 Injection, single (not via indwelling catheter), not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal) (file 1 unit)

62319 Injection, including catheter placement, continuous infusion or intermittent bolus, not including neurolytic substances, with or without contrast (for either localization or epidurography), of diagnostic or therapeutic substance(s) including anesthetic, antispasmodic, opioid, steroid, other solution), epidural or subarachnoid; lumbar, sacral (caudal) (file 1 unit)

The delivering physician must report modifier-TH with 62311 and/or 62319 to identify the service as maternity related.

Pudendal and/or paracervical blocks performed in conjunction with a delivery are inclusive in the obstetrical fee paid to the delivering physician and are not covered as a separate anesthesia service to either the delivering physician or the anesthesia provider.

**ANESTHESIOLOGIST/ CRNA: VAGINAL DELIVERY OR CESAREAN SECTION**

Anesthesiologists and CRNA's must bill the appropriate CPT codes from the CPT range 01958 through 01969 for maternity anesthesia.

General anesthesia for a vaginal delivery is not considered an acceptable standard of medical practice. If the anesthesiologist utilizes this method of anesthesia for a vaginal delivery, a hard copy of the claim must be submitted with anesthesia records which document the medical necessity for general anesthesia.

In maternity cases in which the delivering physician inserts the epidural and later the services of an anesthesiologist or CRNA are required because the patient has a cesarean section and/or tubal ligation, Medicaid will reimburse both the delivering physician and the anesthesiologist or CRNA for their services. In filing claims for reimbursement in this type case, the anesthesiologist or CRNA must bill the same as he/she does for any other maternity anesthesia services.

A maternity epidural has always been covered under Mississippi Medicaid and is not considered an elective procedure. It is the intent of the Division of Medicaid to ensure that all pregnant Medicaid beneficiaries have access to this anesthesia service.

**MATERNITY CPT CODES 01961, 01967, 01968 AND 01969**

The Division of Medicaid has authorized modifications to the methodology for reimbursing maternity anesthesia on certain codes. Effective for dates of service on and after October 1, 2003, the reimbursement for CPT Codes 01961, 01967, 01968 and 01969 will be fee for services (flat fee). Providers must note that CPT Codes 01968 and 01969 are add-on codes and must be billed with CPT 01967. When billing for these codes, the provider must always report one (1) unit in field 24 G of the CMS-1500 claim form.
# CODING GUIDELINES FOR BILATERAL TUBAL LIGATION OR URGENT HYSTERECTOMY FOLLOWING DELIVERY

<table>
<thead>
<tr>
<th>CASE SCENARIO</th>
<th>REIMBURSEMENT</th>
</tr>
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<tbody>
<tr>
<td>A bilateral tubal ligation (BTL) is performed at a distinct separate surgical setting from the delivery.</td>
<td>Provider will bill CPT 00851. Reimbursement methodology will be “base units x base conversion factor plus time units x time conversion factor = total”.</td>
</tr>
<tr>
<td>A bilateral tubal ligation (BTL) is performed under regional or general anesthesia following natural childbirth (no anesthesia utilized for labor).</td>
<td>Provider will bill CPT 00851. Reimbursement methodology will be “base units x base conversion factor plus time units x time conversion factor = total”.</td>
</tr>
<tr>
<td>A bilateral tubal ligation (BTL) is performed at the time of a Cesarean Section.</td>
<td>No additional reimbursement.</td>
</tr>
<tr>
<td>A bilateral tubal ligation (BTL) is performed following vaginal delivery where regional anesthesia was utilized for the labor and delivery.  OR  An urgent hysterectomy is performed following delivery.</td>
<td>Provider will bill for both the labor epidural/delivery (CPT 01967) and the BTL (CPT 00851) or urgent hysterectomy (CPT 01962).  The first (labor epidural/delivery – flat fee) will end and the second procedure (BTL or urgent hysterectomy – base plus time reimbursement) will begin utilizing the following criteria.  (A) If the delivery occurs in a different room and table than where the BTL procedure or urgent hysterectomy will be performed, the anesthesia start time on the second procedure begins when the patient is moved on to the operation table for the BTL procedure or urgent hysterectomy.  (B) If the delivery occurs in the same room and table where the BTL procedure or urgent hysterectomy will be performed, the anesthesia start time will begin when the surgical nurse begins to prepare the patient for the BTL procedure or urgent hysterectomy.</td>
</tr>
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</table>

## Modifiers

In addition to reporting modifiers AA, GC, QX, or QZ for maternity anesthesia, providers must also bill modifier -TH with the procedure. Modifier -TH replaces maternity type of service “B” formerly used in the legacy MMIS system. HIPPA requirements eliminated type of service codes. In order for providers to have an identifier to bypass PRO Utilization Management/ Quality Improvement Organization (UM/QIO) certification requirements on three (3) two (2) day vaginal delivery or five (5) four (4) day cesarean section admissions, the Division of Medicaid is utilizing modifier -TH. Modifier -TH should be reported after the modifier AA, GC, QX, or QZ for three (3) two (2) day vaginal delivery or five (5) four (4) day cesarean section admissions. The utilization of modifier -TH is applicable to all codes in the CPT 01958 through 01969 range. In addition, modifier -TH should be reported with the code for Bilateral Tubal Ligation (CPT 00851) when performed during three (3) two (2) day vaginal delivery or five (5) four (4) day cesarean section admissions.

## ALL OTHER CODES IN THE CPT 00100 through 01999 RANGE

Providers will continue to bill for all other covered anesthesia services in the CPT 00100 through 01999 range by reporting the appropriate CPT code and time units. One minute of anesthesia time will equal one (1) unit.