

## Anesthesia Policy, Professional

### **IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY**

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare reimbursement policies may use Current Procedural Terminology (CPT®\*), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general reference resource regarding UnitedHealthcare's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, the enrollee's benefit coverage documents and/or other reimbursement, medical or drug policies. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare due to programming or other constraints; however, UnitedHealthcare strives to minimize these variations.

UnitedHealthcare may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

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### Application

This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or

its electronic equivalent or its successor form. This policy applies to all products, all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

**Policy**

**Overview**

UnitedHealthcare's reimbursement policy for anesthesia services is developed in part using the American Society of Anesthesiologists (ASA) Relative Value Guide (RVG®), the ASA CROSSWALK®, and Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) Policy Manual, CMS NCCI edits and the CMS National Physician Fee Schedule.

Current Procedural Terminology (CPT®) codes and modifiers and Healthcare Common Procedure Coding System (HCPCS) modifiers identify services rendered. These services may include, but are not limited to, general or regional anesthesia, Monitored Anesthesia Care, or other services to provide the patient the medical care deemed optimal.

The Anesthesia Policy addresses reimbursement of procedural or pain management services that are an integral part of anesthesia services as well as anesthesia services that are an integral part of procedural services.

**Reimbursement Guidelines**

**Anesthesia Services**

Anesthesia services must be submitted with a CPT anesthesia code in the range 00100-01999, excluding 01953 and 01996, and are reimbursed as time-based using the Standard Anesthesia Formula. Refer to the attached Anesthesia Codes list for all applicable codes.

For purposes of this policy the code range 00100-01999 specifically excludes 01953 and 01996 when referring to anesthesia services. CPT codes 01953 and 01996 are not considered anesthesia services because, according to the ASA RVG®, they should not be reported as time-based services.

**Modifiers**

Required Anesthesia Modifiers	All anesthesia services including Monitored Anesthesia Care must be submitted with a required anesthesia modifier in the first modifier position. These modifiers identify whether a procedure was personally performed, medically directed, or medically supervised. Consistent with CMS, UnitedHealthcare will adjust the Allowed Amount by the Modifier Percentage indicated in the table below.	Reimbursement Percentage
<b>AA</b>	Anesthesia services performed personally by an anesthesiologist.	<b>100%</b>
<b>AD</b>	Medical supervision by a physician: more than four concurrent anesthesia procedures. *For additional information, refer to Standard Anesthesia Formula with Modifier AD under <a href="#">Reimbursement Formula</a>	<b>100%</b>
<b>QK</b>	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals.	<b>50%</b>
<b>QX</b>	Qualified nonphysician anesthetist with medical direction by a physician	<b>50%</b>
<b>QY</b>	Medical direction of one qualified nonphysician anesthetist by an anesthesiologist	<b>50%</b>
<b>QZ</b>	CRNA service; without medical direction by a physician.	<b>100%</b>

Other Modifiers	These CPT and HCPCS modifiers may be reported to identify an altered circumstance for anesthesia and pain management.	Additional Information
22	Increased Procedural Services	See <a href="#">Questions and Answers</a> section, Q&A #9
59	Distinct Procedural Service	
76	Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional	
77	Repeat Procedure by Another Physician or Other Qualified Health Care Professional	
78	Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period	
79	Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period	
XE	Separate encounter: a service that is distinct because it occurred during a separate encounter	
XU	Unusual non-overlapping service: the use of a service that is distinct because it does not overlap usual components of the main service	
Physical Status Modifiers	CPT and ASA guidelines identify six levels of ranking for patient physical status. Appending a physical status modifier to a time-based anesthesia code identifies the level of complexity and Modifying Unit(s) are added to the Base Unit Value for the most complex situations. If more than one physical status modifier (P3, P4, or P5) is submitted, the modifier with the highest number of units is the reimbursable service.	Modifying Units Added to the Base Unit Value
P1	A physical status modifier for a normal healthy patient.	0 units
P2	A physical status modifier for a patient with mild systemic disease.	0 units
P3	A physical status modifier for a patient with severe systemic disease.	1 unit
P4	A physical status modifier for a patient with severe systemic disease that is a constant threat to life.	2 units
P5	A physical status modifier for a moribund patient who is not expected to survive without the operation.	3 units
P6	A physical status modifier for a declared brain-dead patient whose organs are being removed for donor purposes.	0 units
Informational Modifiers	If reporting CPT modifier 23 or 47 or HCPCS modifier GC, G8, G9 or QS then no additional reimbursement is allowed above the usual fee for that service.	Reimbursement
23	Unusual Anesthesia	<b>No additional-</b> This is considered an informational modifier only.
47	Anesthesia by Surgeon	<b>No additional -</b> This is considered an informational modifier only.

<b>GC</b>	This service has been performed in part by a resident under the direction of a teaching physician	<b>No additional -</b> This is considered an informational modifier only.
<b>G8</b>	Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure	<b>No additional –</b> This is considered an informational modifier only which should be billed along with a required anesthesia modifier and not be in the first modifier position
<b>G9</b>	Monitored anesthesia care (MAC) for patient who has a history of severe cardiopulmonary condition	<b>No additional –</b> This is considered an informational modifier only which should be billed along with a required anesthesia modifier and not be in the first modifier position
<b>QS</b>	Monitored anesthesiology care services (can be billed by a qualified nonphysician anesthetist or a physician)	<b>No additional –</b> This is considered an informational modifier only which should be billed along with a required anesthesia modifier and not be in the first modifier position
<b>XP</b>	Separate practitioner: a service that is distinct because it was performed by a different practitioner	
<b>XS</b>	Separate structure: a service that is distinct because it was performed on a separate organ/structure	

**Reimbursement Formula**

**Base Values:**

Each CPT anesthesia code (00100-01999) is assigned a Base Value by the ASA, and UnitedHealthcare uses these values for determining reimbursement. The Base Value of each code is comprised of units referred to as the Base Unit Value.

**Time Reporting:**

Consistent with CMS guidelines, UnitedHealthcare requires time-based anesthesia services be reported with actual Anesthesia Time in one-minute increments. For example, if the Anesthesia Time is one hour, then 60 minutes should be submitted.

The ASA indicates that post- surgical pain blocks are frequently placed before anesthesia induction or after anesthesia emergence. When the block is placed before induction or after emergence, the time spent placing the block should not be added to the reported anesthesia time; this is true even if sedation and monitoring is provided to the patient during block

placement.

**Reimbursement Formulas:**

Time-based anesthesia services are reimbursed according to the following formulas:

**Standard Anesthesia Formula without Modifier AD\*** = ([Base Unit Value + Time Units + Modifying Units] x Conversion Factor) x Modifier Percentage.

**Standard Anesthesia Formula with Modifier AD\*** = ([Base Unit Value of 3 + 1 Additional Unit if anesthesia notes indicate the physician was present during induction] x Conversion Factor) x Modifier Percentage.

\*For additional information, Refer to [Modifiers](#).

**Qualifying Circumstances**

Qualifying circumstances codes identify conditions that significantly affect the nature of the anesthetic service provided. Qualifying circumstances codes should only be billed in addition to the anesthesia service with the highest Base Unit Value. The Modifying Units identified by each code are added to the Base Unit Value for the anesthesia service according to the above Standard Anesthesia Formula.

Procedure Code	CPT Code Description	Modifying Units
99100	Anesthesia for patient of extreme age, younger than 1 year and older than 70 (List separately in addition to code for primary anesthesia procedure). <i>(Per the ASA RVG® an additional unit for 99100 is not allowed with anesthesia codes 00326, 00561, 00834 and 00836)</i>	1 unit
99116	Anesthesia complicated by utilization of total body hypothermia (List separately in addition to code for primary anesthesia procedure). <i>(Per the ASA RVG® additional units for 99116 are not allowed with anesthesia codes 00561, 00562, 00563 and 00567)</i>	5 units
99135	Anesthesia complicated by utilization of controlled hypotension (List separately in addition to code for primary anesthesia procedure). <i>(Per the ASA RVG® additional units for 99135 are not allowed with anesthesia codes 00561, 00562, 00563 and 00567)</i>	5 units
99140	Anesthesia complicated by emergency conditions (specify) (List separately in addition to code for primary anesthesia procedure)  <b>(An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part.)</b>	2 units

**Additional Information:**

Anesthesia when surgery has been cancelled – Refer to the [Questions and Answers](#) section, Q&A #3, for additional information.

For information on reporting Certified Registered Nurse Anesthetist (CRNA) services, refer to the [Questions and Answers](#) section, Q&A #4.

**Multiple or Duplicate Anesthesia Services**

**Multiple Anesthesia Services:**

According to the ASA, when multiple surgical procedures are performed during a single anesthesia administration, only the single anesthesia code with the highest Base Unit Value is reported. The time reported is the combined total for all procedures performed on the same patient on the same date of service by the same or different physician or other qualified health care professional. Add-on anesthesia codes (01953, 01968 and 01969) are exceptions to this and are addressed in the Anesthesia Services section and Obstetric Anesthesia Services section of this policy. UnitedHealthcare aligns with these ASA coding guidelines. Specific reimbursement percentages are based on the anesthesia modifier(s) reported.

**Duplicate Anesthesia Services:**

When duplicate (same) anesthesia codes are reported by the same or different physician or other qualified health care professional for the same patient on the same date of service, UnitedHealthcare will only reimburse the first submission of that code. However, anesthesia administration services can be rendered simultaneously by an MD and a CRNA during the same operative session, each receiving 50% of the Allowed Amount (as indicated in the Modifier Table above) by reporting modifiers QK or QY and QX.

In the event an anesthesia administration service is provided during a different operative session on the same day as a previous operative session, UnitedHealthcare will reimburse one additional anesthesia administration appended with modifier 59, 76, 77, 78, 79 or XE. As with the initial anesthesia administration, only the single anesthesia code with the highest Base Unit Value should be reported.

Refer to the [Modifiers](#) and [Reimbursement Formula](#) sections of the policy for additional information.

**Anesthesia and Procedural Bundled Services**

UnitedHealthcare sources anesthesia edits to methodologies used and recognized by third party authorities (referenced in the Overview section) when considering procedural or pain management services that are an integral part of anesthesia services, and anesthesia services that are an integral part of procedural or pain management services. Those methodologies can be Definitive or Interpretive. A Definitive source is one that is based on very specific instructions from the given source. An Interpreted source is one that is based on an interpretation of instructions from the identified source (see the Definitions section below for further explanations of these sources). Where CMS NCCI edits exist these edits are managed under the UnitedHealthcare "CCI Editing Policy".

Procedural/pain management services or anesthesia services that are identified as bundled (integral) are not separately reimbursable when performed by the Same Individual Physician or Other Qualified Health Care Professional on the same date of service. The Same Individual Physician or Other Qualified Health Care Professional is defined as the same individual rendering health care services reporting the same Federal Tax Identification number.

**Procedural or Pain Management Services Bundled in Anesthesia Services:**

- Services in the CMS National Physician Fee Schedule that have a status indicator of B (Bundled code) or T (Injections);
- Services that are not separately reimbursed with anesthesia services as stated in the CMS NCCI Policy Manual, Chapter 2 although they are not specifically listed in that manual: 64561, 82800, 82803, 82805, 82810, 85345, 85347, 85348;
- Nerve Block codes billed in conjunction with anesthesia services when modifier 59, XE or XU is not appended to the nerve block code

The above CPT and HCPCS codes are included in the following list:

[2019 Procedural or Pain Management Codes Bundled into Anesthesia](#)

The CMS NCCI Policy manual states that "many standard preparation, monitoring, and procedural services are considered integral to the anesthesia service. Although some of the services would never be appropriately reported on the



same date of service as anesthesia management, many of these services could be provided at a separate patient encounter unrelated to the anesthesia management on the same date of service." Anesthesia Professionals may identify these separate encounters by reporting a modifier 59, XE or XU. For CPT and HCPCS codes included on the Procedural or Pain Management Codes Bundled into Anesthesia list that will be considered distinct procedural services when modifier 59, XE or XU is appended, refer to the following list:

[2019 Procedural or Pain Management Bundled Codes Allowed with Modifiers](#)

**Anesthesia Services Bundled in Procedural Services:**

According to the NCCI Policy Manual, Chapter 1, CMS does not allow separate payment for anesthesia services performed by the physician who also furnishes the medical or surgical procedure, excluding Moderate Sedation. In these situations, the allowance for the anesthesia service is included in the payment for the medical or surgical procedure. In addition, AMA states "if a physician personally performs the regional or general anesthesia for a surgical procedure that he or she also performs, modifier 47 would be appended to the surgical code, and no codes from the anesthesia section would be used."

UnitedHealthcare will not separately reimburse an anesthesia service when reported with a medical or surgical procedure (where the anesthesia service is the direct or alternate crosswalk code for the medical or surgical procedure) submitted by the Same Individual Physician or Other Qualified Health Care Professional for the same patient on the same date of service. For medical/surgical procedures reported using CPT codes, the direct and alternate crosswalk anesthesia codes are obtained from the ASA CROSSWALK®. For medical/surgical procedures reported as HCPCS codes, the direct and alternate crosswalk anesthesia codes are obtained from CMS NCCI edits and interpretation of other CMS sources. A listing of interpretive edits titled "[Anesthesia Services Bundled into HCPCS Procedural Codes](#)" can be found in the Attachments section below.

Refer to the publication ASA CROSSWALK® for a listing of medical or surgical procedures and the corresponding direct or alternate crosswalk anesthesia service.

Refer to the [Questions and Answers](#) section, Q&A #1 and #2 for additional information.

**Preoperative/Postoperative Visits**

Consistent with CMS, UnitedHealthcare will not separately reimburse an E/M service (excluding critical care CPT codes 99291-99292) when reported by the Same Specialty Physician or Other Qualified Health Care Professional on the same date of service as an anesthesia service.

Critical care CPT codes 99291-99292 are not considered included in an anesthesia service and will be separately reimbursed.

The Same Specialty Physician or Other Qualified Health Care Professional is defined as physicians and/or other qualified health care professionals of the same group and same specialty reporting the same Federal Tax Identification number.

[2019 Evaluation and Management Codes Bundled into Anesthesia](#)

**Daily Hospital Management**

Daily hospital management of epidural or subarachnoid drug administration (CPT code 01996) in a CMS place of service 19 (off campus outpatient hospital), 21 (inpatient hospital), 22 (on campus outpatient hospital) or 25 (birthing center) is a separately reimbursable service once per date of service excluding the day of insertion. CPT code 01996 is considered included in the pain management procedure if submitted on the same date of service by the Same Individual Physician or Other Qualified Health Care Professional.

If the anesthesiologist continues with the patient's care after discharge, the appropriate Evaluation and Management code should be used.

**Obstetric Anesthesia Services**

**Neuraxial Labor Analgesia Reimbursement Calculations**

Consistent with a method described in the ASA RVG® UnitedHealthcare will reimburse neuraxial labor analgesia (CPT code 01967) based on Base Unit Value plus Time Units subject to a cap of 435 minutes. Modifying Units for physical status modifiers and qualifying circumstance codes will be considered in addition to the Base Unit Value for labor or delivery anesthesia services in accordance with the Standard Anesthesia Formula (refer to the [Reimbursement Formula](#) section of the policy above).

**Obstetric Add-On Codes**

Obstetric Anesthesia often involves extensive hours and the transfer of anesthesia to a second physician. Due to these unique circumstances, UnitedHealthcare will consider for reimbursement, add-on CPT codes 01968 and 01969 (c- section anesthesia) when billed with the primary CPT code 01967 (by the same or different individual physician or other qualified healthcare professional) for the same member. According to the ASA Crosswalk® time for add-on code 01968 or 01969 is reported separately as a surgical anesthesia service and is not added to the time reported for the labor anesthesia service.

**Obstetric Anesthesia: Neuraxial Labor Analgesia Reimbursement Calculations**

**Example 1:** 200 minutes are reported for labor and delivery services on a single claim line with CPT code 01967: The total 200 minutes will be added to the Base Unit Value for CPT code 01967.

**Example 2:** 500 minutes are reported for labor and delivery services on a single claim line with CPT code 01967: A capped 435 minutes will be added to the Base Unit Value for CPT code 01967.

**Example 3:** Labor and delivery services are reported on multiple claim lines with CPT code 01967 at 200 minutes and add-on CPT code 01968 at 75 minutes: 200 minutes will be added to the Base Unit Value for CPT code 01967 and 75 minutes will be added to the Base Unit Value for CPT code 01968.

**Example 4:** Labor and delivery services are reported on multiple claim lines with CPT code 01967 at 700 minutes, add-on CPT code 01968 at 75 minutes, and qualifying circumstance code 99140: A capped 435 minutes for CPT code 01967 and 30 minutes for qualifying circumstance code 99140 will be added to the Base Unit Value for CPT code 01967 and 75 minutes will be added to the Base Unit Value for CPT code 01968.

**Definitions**

<b>Allowable Amount</b>	Defined as the dollar amount eligible for reimbursement to the physician or other qualified health care professional on the claim. Contracted rate, reasonable charge, or billed charges are examples of an Allowable Amount, whichever is applicable. For percent of charge or discount contracts, the Allowable Amount is determined as the billed amount, less the discount.
<b>Anesthesia Professional</b>	An Anesthesiologist, a Certified Registered Nurse Anesthetist (CRNA), Anesthesia Assistant (AA), or other qualified individual working independently or under the medical supervision of a physician.
<b>Anesthesia Time</b>	Anesthesia Time begins when the Anesthesia Professional prepares the patient for the induction of anesthesia in the operating room or in an equivalent area (i.e. a place adjacent to the operating room) and ends when the Anesthesia Professional is no longer in personal attendance and when the patient may be safely placed under postoperative supervision. Anesthesia Time involves the continuous actual presence of the Anesthesia Professional.
<b>Base Unit Value</b>	The number of units which represent the Base Value (per code) of all usual anesthesia services, except the time actually spent in anesthesia care and any



	Modifying Units.
<b>Base Value</b>	The Base Value includes the usual preoperative and postoperative visits, the administration of fluids and/or blood products incident to the anesthesia care, and interpretation of non-invasive monitoring (ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry). Placement of arterial, central venous and pulmonary artery catheters and use of transesophageal echocardiography (TEE) are not included in the Base Value.
<b>Conversion Factor</b>	The incremental multiplier rate defined by specific contracts or industry standards. For non-network physicians the applied Conversion Factor is based on a recognized national source.
<b>Definitive Source</b>	Definitive Sources contain the exact codes, modifiers or very specific instructions from the given source.
<b>Interpretive Source</b>	An edit source that includes guidelines; however, no exact or specific code or modifier information is listed. Therefore, an interpretation must be made as to what codes correlate to the guidelines. Additionally, an interpretation may be applied to surrounding or similar codes based on related definitively sourced edits.
<b>Moderate Sedation</b>	Moderate (conscious) Sedation is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. Moderate Sedation does not include minimal sedation (anxiolysis), deep sedation, or monitored anesthesia care (CPT codes 00100-01999).
<b>Modifier Percentage</b>	Reimbursement percentage allowed for anesthesia services which are personally performed, medically directed or medically supervised as defined by the modifier (i.e. 50% for the modifier QK).
<b>Modifying Units</b>	Time Units added for additional reimbursement allowed as defined by the physical status modifier or qualifying circumstances codes reported (i.e. One additional unit added to the Base Unit Value for appending modifier P3).
<b>Monitored Anesthesia Care</b>	<p>Per the ASA Monitored Anesthesia Care includes all aspects of anesthesia care – a preprocedure visit, intraprocedure care and postprocedure anesthesia management. During Monitored Anesthesia Care, the anesthesiologist provides or medically directs a number of specific services, including but not limited to:</p> <ul style="list-style-type: none"> <li>• Diagnosis and treatment of clinical problems that occur during the procedure</li> <li>• Support of vital functions</li> <li>• Administration of sedatives, analgesics, hypnotics, anesthetic agents or other medications as necessary for patient safety</li> <li>• Psychological support and physical comfort</li> <li>• Provision of other medical services as needed to complete the procedure safely.</li> </ul> <p>Monitored Anesthesia Care may include varying levels of sedation, analgesia and anxiolysis as necessary. The provider of Monitored Anesthesia Care must be prepared and qualified to convert to general anesthesia when necessary.</p> <p>Modifiers G8, G9 and QS are used to identify Monitored Anesthesia Care.</p>
<b>Same Individual Physician or Other Qualified Health Care Professional</b>	The same individual rendering health care services reporting the same Federal Tax Identification number.
<b>Same Specialty Physician or Other Qualified Health Care Professional</b>	Physicians and/or other qualified health care professionals of the same group and same specialty reporting the same Federal Tax Identification number.





<b>Standard Anesthesia Formula</b>	Refers to either the Standard Anesthesia Formula with Modifier AD or the Standard Anesthesia Formula without Modifier AD, as appropriate. See the Reimbursement Formula section of this policy for descriptions of those terms.
<b>Time Units</b>	The derivation of units based on time reported which is divided by a time increment generally of 15 minutes. Note: Consistent with CMS guidelines, UnitedHealthcare requires time-based anesthesia services be reported with actual Anesthesia Time in one-minute increments.


Questions and Answers	
<b>1</b>	<p><b>Q:</b> How should anesthesia services performed by the Anesthesia Professional be reported when the medical or surgical procedure is performed by a different physician or other qualified health care professional?</p> <p><b>A:</b> For general or monitored anesthesia services, in support of a non-anesthesia service, please refer to the ASA CROSSWALK® and report the appropriate CPT anesthesia code (00100 - 01999).</p>
<b>2</b>	<p><b>Q:</b> How should anesthesia services performed by the same physician who also furnishes the medical or surgical procedure be reported?</p> <p><b>A:</b> If a physician personally performs the anesthesia for a medical or surgical procedure that he or she also performs, modifier 47 would be appended to the medical or surgical code, and no codes from the anesthesia section of the CPT codebook would be used.</p>
<b>3</b>	<p><b>Q:</b> How should anesthesia services be reported when surgery has been cancelled?</p> <p><b>A:</b> If surgery is cancelled after the Anesthesia Professional has performed the preoperative examination but before the patient has been prepared for the induction of anesthesia, report the appropriate Evaluation &amp; Management code for the examination only. If surgery is cancelled after the Anesthesia Professional has prepared the patient for induction, report the most applicable anesthesia code with full base and time. The Anesthesia Professional is not required to report the procedure as a discontinued service using modifier 53.</p>
<b>4</b>	<p><b>Q:</b> How should a CRNA report anesthesia services?</p> <p><b>A:</b> CRNA services should be reported with the appropriate anesthesia modifier QX or QZ. CRNA services must be reported under the supervising physician's name or the employer or entity name under which the CRNA is contracted. In limited circumstances, when the CRNA is credentialed and/or individually contracted by UnitedHealthcare, CRNA services must be reported under the CRNA's name.</p>
<b>5</b>	<p><b>Q:</b> How should a teaching anesthesiologist report anesthesia services for two resident cases?</p> <p><b>A:</b> Consistent with CMS policy, the teaching anesthesiologist may report the actual Anesthesia Time (see definitions) for each case with modifiers AA and GC.</p>
<b>6</b>	<p><b>Q:</b> CPT code 01967 (Neuraxial labor analgesia/anesthesia for planned vaginal delivery) is performed by an Anesthesia Professional for a single anesthetic administration. CPT code 00851 (Anesthesia for intraperitoneal procedures in the lower abdomen including laparoscopy; tubal ligation/transection) is subsequently performed by the same Anesthesia Professional during a separate operative session with a single anesthetic administration on the same date of service for the same patient. How should the anesthesia services be reported?</p> <p><b>A:</b> Report CPT code 01967 with the appropriate anesthesia modifier and time. Report CPT code 00851 with the appropriate anesthesia modifier and time and in addition, modifier 59, 76, 77, 78, 79 or XE to indicate the anesthesia service was separate and subsequent to the original anesthesia service reported with CPT code 01967.</p>
<b>7</b>	<p><b>Q:</b> When physician medical direction is provided to a Certified Registered Nurse Anesthetist (CRNA) for an anesthesia service and a qualifying circumstance exists, who should report the qualifying circumstance code(s) when the services are reported on separate claims?</p>

	<p><b>A:</b> Both the supervising physician and the CRNA should report the qualifying circumstance code(s), so that the additional unit(s) for the qualifying circumstance code(s) will be added to the Base Unit Value according to the Standard Anesthesia Formula and adjusted by the appropriate anesthesia Modifier Percentage (CRNA reported with modifier QX and physician reported with modifier QK or QY).</p>									
<b>8</b>	<p><b>Q:</b> When physician medical direction is provided to an Anesthesia Assistant (AA) for an anesthesia service, how should the service for the AA and the supervising physician be reported?</p> <p><b>A:</b> UnitedHealthcare aligns with CMS and considers anesthesia assistants eligible for the same level of reimbursement as a CRNA; however, while CRNAs can be either medically directed or work on their own, AAs must work under the medical direction of an anesthesiologist. Therefore, in the instance a physician has medically directed an AA, the AA should report the anesthesia service with modifier QX and the supervising physician should report the same anesthesia service with modifier QK, QY or AD.</p>									
<b>9</b>	<p><b>Q:</b> Will anesthesia services submitted with modifier 22 qualify for additional reimbursement?</p> <p><b>A:</b> Only anesthesia services with a Base Unit Value less than 5 units appended with modifier 22 for unusual positioning and field avoidance would be considered for additional reimbursement when submitted with supporting documentation. Other anesthesia services will not be allowed additional reimbursement for modifier 22.</p> <p>Anesthesia services are reimbursed according to the ASA assigned Base Unit Value plus Time Units; services with a Base Unit Value of 5 or greater already take positioning and field avoidance if any into account. Additionally physical status modifiers and qualifying circumstance codes may be reported to distinguish various levels of complexity or to identify conditions that significantly affect the character of anesthesia services. Therefore, the Base Unit Value, Time Units, physical status modifiers and qualifying circumstance codes already provide a means for an appropriate level of reimbursement for anesthesia services.</p>									
<b>10</b>	<p><b>Q:</b> What is the best approach to take to submit supporting documentation for modifier 22?</p> <p><b>A:</b> Submit a paper claim using the CMS form accompanied by the requested documentation.</p>									
<b>11</b>	<p><b>Q:</b> The policy states time-based anesthesia services should be submitted using actual time in one-minute increments. How would minutes be reported for paper and electronic claim submissions?</p> <p><b>A:</b> The 1500 Health Insurance Claim Form Reference Instruction Manual located at <a href="http://www.nucc.org">www.nucc.org</a> provides the following instructions:</p> <p><b>Paper Claims with CMS Paper Format 02-12:</b> item number 24G titled Days or Units [lines 1–6] should be completed as follows:</p> <ul style="list-style-type: none"> <li>• Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia units or minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered.</li> <li>• Enter numbers left justified in the field. No leading zeros are required. If reporting a fraction of a unit, use the decimal point.</li> <li>• Anesthesia services <u>must</u> be reported as minutes. Units may <u>only</u> be reported for anesthesia services when the code description includes a time period (such as “daily management”).</li> </ul> <p><b>Electronic Claims:</b> Below is a crosswalk of the 02-12 version 1500 Health Care Claim Form (1500 Claim Form) to the X12 837 Health Care Claim: Professional Version 5010/5010A1 electronic transaction. Please refer to the X12 Health Care Claim: Professional (837) Technical Report Type 3 for more specific details on the transaction and data elements.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 33%;">1500 form</th> <th style="width: 33%;">837P</th> <th style="width: 34%;">Notes</th> </tr> <tr> <th>Item Number/Title</th> <th>Loop ID/Segment Data Element</th> <th></th> </tr> </thead> <tbody> <tr> <td>24G/Days or Units</td> <td>2400/SV104</td> <td>Titled Service Unit Count in the 837P</td> </tr> </tbody> </table>	1500 form	837P	Notes	Item Number/Title	Loop ID/Segment Data Element		24G/Days or Units	2400/SV104	Titled Service Unit Count in the 837P
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Item Number/Title	Loop ID/Segment Data Element									
24G/Days or Units	2400/SV104	Titled Service Unit Count in the 837P								

	Use of the updated version of the CMS 1500 paper format (02-12) is encouraged. For additional information, refer to the National Uniform Claim Committee (NUCC) Website: <a href="http://www.nucc.org">www.nucc.org</a>
<b>12</b>	<p><b>Q:</b> How will reimbursement for anesthesia services reported with anesthesia modifiers QY, QK, and QX be calculated when the physician or other qualified health care professional is contracted at a percent of charge?</p> <p><b>A:</b> UnitedHealthcare calculates percent of charge allowances and then applies reductions of 50% for anesthesia modifiers QY, QK, and QX when the claim is processed. Example: An anesthesiologist is contracted at 50% percent of charge provides medical direction of a CRNA. The total fee for this service is \$1200.00. The Allowed Amount at 50% would be \$600.00. An additional 50% reduction for the modifier QK would be applied therefore the final Allowed Amount would be \$300.00.</p>
<b>13</b>	<p><b>Q:</b> What guidelines are available for reporting anesthesia teaching services?</p> <p><b>A:</b> Information on reporting anesthesia teaching services is available in the Department of Health and Human Services <i>Federal Register</i> publication, November 25, 2009 edition, page 61867. A link to the <i>Federal Register</i> is located in the <a href="#">Resources</a> section.</p> <p>Note that reimbursement for anesthesia services is based on the specific modifier reported. Refer to the <a href="#">Reimbursement Formula</a> and <a href="#">Modifiers</a> sections.</p>
<b>14</b>	<p><b>Q:</b> Is the use of a brain function monitor for intraoperative awareness as defined in the ASA Practice Advisory “Intraoperative Awareness and Brain Function Monitoring” a separately reportable service in conjunction with an anesthetic service?</p> <p><b>A:</b> According to ASA RVG®, the use of a brain function monitor for intraoperative awareness is not separately reportable in conjunction with an anesthetic service.</p>
<b>15</b>	<p><b>Q:</b> Can CPT codes 62320-62327 (Epidural or subarachnoid injections of diagnostic or therapeutic substances – bolus, intermittent bolus, or continuous infusion) be reported on the date of surgery when performed for postoperative pain management rather than as the means for providing the regional block for the surgical procedure?</p> <p><b>A:</b> Yes, an epidural or subarachnoid injection of a diagnostic or therapeutic substance may be separately reported for postoperative pain management with an anesthesia code (i.e. CPT 01470) if it is not utilized for operative anesthesia, but is utilized for postoperative pain management. Modifier 59, XE or XU must be appended to the epidural or subarachnoid injection code to indicate a distinct procedural service was performed.</p>

**Attachments: Please right-click on the icon to open the file**

 <b>Anesthesia Codes</b>	Identifies codes that are considered anesthesia (base + time) services.
 <b>Evaluation and Management Codes Bundled into Anesthesia</b>	Identifies Evaluation and Management codes considered to be included in the Base Unit Value for the anesthesia service.
 <b>Procedural or Pain Management Codes Bundled into Anesthesia</b>	Identifies codes included in the Base Unit Value for the anesthesia service.
 <b>Procedural or Pain</b>	Identifies codes included in the Procedural or Pain Management Codes Bundled into Anesthesia list that will be considered separate from the anesthesia service when modifier 59, XE or XU is appended to identify a separate encounter unrelated to the

<b>Management Bundled Codes Allowed with Modifiers</b>	anesthesia service on the same date of service.
 <b>Anesthesia Services Bundled into HCPCS Procedural Codes</b>	Identifies medical/surgical procedures reported as HCPCS codes and their direct or alternate crosswalk anesthesia codes

## Resources

- American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services
- American Society of Anesthesiologists, Relative Value Guide®
- Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
- Centers for Medicare and Medicaid Services, National Correct Coding Initiative (NCCI) publications
- Centers for Medicare and Medicaid Services, Physician Fee Schedule (PFS) Relative Value Files
- National Uniform Claim Committee (NUCC)
- Publications and services of the American Society of Anesthesiologists (ASA)

***Federal Register***

Vol. 74, No. 226  
 Wednesday, November 25, 2009  
 Page 61867  
 Centers for Medicare and Medicaid Services, Medicare Program  
**Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B (for CY 2010)**  
**Section 139: Improvements for Medicare Anesthesia Teaching Programs**  
<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS1230135.html?DLPage=3&DLEntries=10&DLSort=2&DLSortDir=descending>

## History

<b>9/30/2019</b>	Policy Version Change Update to the Reimbursement Formula and other sections to align with C&S Medicaid Anesthesia Policy
<b>2/10/2019</b>	Policy Version Change Policy List Changes: Anesthesia Services Bundled into HCPCS Procedural Codes
<b>2/1/2019 – 2/9/2019</b>	Annual Anniversary Date and Version Change Title section: Removed Annual Approval information & moved policy number to the header
<b>1/1/2019 – 1/31/2019</b>	Policy Version Change Adding 'Professional' to the policy title Application: Removed Community and State and Medicare and Retirement information Overview: Removed reference to other UnitedHealthcare reimbursement policies Reimbursement Guidelines: Removed CPT 00566 from Qualifying Circumstance Table: Added clarifying language to Multiple or Duplicate Anesthesia Attachments: Updated Evaluation and Management Codes Bundled into Anesthesia, Procedural or Pain Management Codes Bundled into Anesthesia, Procedural or Pain Management Bundled

	Codes Allowed with Modifier 59 Definitions: Updated Allowable Amount History Section: Entries prior to 1/1/2017 archived
<b>3/14/2018</b>	Policy Approval Date Change (no new version)
<b>2/11/2018 – 12/31/2018</b>	Policy List Changes: Anesthesia Services Bundled into HCPCS Procedural Codes
<b>1/1/2018 – 2/10/2018</b>	Annual Policy Version Change Policy List Changes: Updated Anesthesia Codes, E&M Codes Bundled into Anesthesia, Anesthesia Services Bundled into HCPCS Procedural Codes History Section: Entries prior to 1/1/2016 archived
<b>3/8/2017</b>	Policy Approval Date Change (no new version)
<b>1/1/2017 – 12/31/2017</b>	Annual Policy Version Change Policy List Changes: Updated Evaluation and Management Codes Bundled into Anesthesia, Procedural or Pain Management Codes Bundled into Anesthesia, Procedural or Pain Management Bundled Codes Allowed with Modifier 59 Policy Verbiage Change: Updated the Overview section Questions and Answers: Updated codes in Q&A #15 History Section: Entries prior to 1/1/2015 archived