Anesthesia Services Policy, Professional

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

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 Medicare Advantage reimbursement policies 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 (CMS 1450). 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 resource regarding UnitedHealthcare Medicare Advantage reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Medicare Advantage 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 Medicare Advantage 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, and/or the enrollee's benefit coverage documents. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Medicare Advantage due to programming or other constraints; however, UnitedHealthcare Medicare Advantage strives to minimize these variations.

UnitedHealthcare Medicare Advantage may modify this reimbursement policy at any time to comply with changes in CMS policy and other national standard coding guidelines by publishing a new version of the reimbursement policy on this website. However, the information presented in this reimbursement policy is accurate and current as of the date of publication. UnitedHealthcare Medicare Advantage encourages physicians and other health care professionals to keep current with any CMS policy changes and/or billing requirements by referring to the CMS or your local carrier website regularly. Physicians and other health care professionals can sign up for regular distributions for policy or regulatory changes directly from CMS and/or your local carrier. UnitedHealthcare's Medicare Advantage reimbursement policies do not include notations regarding prior authorization requirements.

** For more information on a specific enrollee's benefit coverage, please call the customer service number on the back of the member ID card.

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 and all network physicians and other qualified health care professionals, including, but not limited to percent of charge contract physicians and other qualified health care professionals.

Policy

Overview

UnitedHealthcare Medicare Advantage'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) methodology.

Current Procedural Terminology (CPT®) codes and modifiers and Health Care 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 or pain management services.

Reimbursement Guidelines

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.

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.

Reimbursement Formula

Base Values:
Each CPT anesthesia code is assigned a Base Value by the ASA, and UnitedHealthcare Medicare Advantage 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 Medicare Advantage 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. Consistent with CMS guidelines, UnitedHealthcare Medicare Advantage does not allow additional base units for qualifying circumstance codes. The qualifying circumstances codes are 99100, 99116, 99135 and 99140.

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.

Code 01953 is an add-on-code and is used in conjunction with code 01952. Codes 01968 and 01969 are add-on-codes and are used in conjunction with code 01967. Anesthesia add-on codes are priced differently. Only the base unit of the add-on code should be allowed. The anesthesia time should be reported with the primary anesthesia code.

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 Medicare Advantage will only reimburse the first submission of that code. Specific reimbursement percentages are based on the anesthesia modifier(s) reported.

Anesthesia and Procedural Bundled Services
UnitedHealthcare Medicare Advantage uses the CMS National Correct Coding Initiative (NCCI) Policy Manual, CMS NCCI edits and the CMS National Physician Fee Schedule 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, which are not separately reimbursable when performed by the Same Individual Physician or Other Qualified Health Care Professional on the same date of service.

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." 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.

Preoperative/Postoperative Visits
Consistent with CMS, UnitedHealthcare Medicare Advantage 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.

Daily Hospital Management
Daily hospital management of epidural or subarachnoid drug administration (CPT code 01996) in a CMS place of service 21 (inpatient hospital), 22 (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.

For purposes of this policy, Same Physician or Other Qualified Health Care Professional is defined as the same individual rendering health care services reporting the same Federal Tax Identification number.

Definitions	
Allowable Amount	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.
Anesthesia Professional	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.
Anesthesia Time	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.
Base Unit Value	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.
Base Value	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.
Conversion Factor	The incremental multiplier rate defined by specific contracts or industry standards.
Modifier Percentage	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).
Monitored Anesthesia Care	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: • Diagnosis and treatment of clinical problems that occur during the procedure • Support of vital functions • Administration of sedatives, analgesics, hypnotics, anesthetic agents or other medications as necessary for patient safety • Psychological support and physical comfort • Provision of other medical services as needed to complete the procedure safely. 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. Modifiers G8, G9 and QS are used to identify Monitored Anesthesia Care.
Same Individual Physician or Other Qualified Health Care Professional	The same individual rendering health care services reporting the same Federal Tax Identification number.

Same Specialty Physician or Other Qualified Health Care Professional	Physicians and/or other qualified health care professionals of the same group and same specialty reporting the same Federal Tax Identification number.
Standard Anesthesia Formula	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.
Time Units	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	
1	**Q:** When modifier PT is billed does the member have a cost share? **A:** Coinsurance and deductible does not apply to anesthesia claim lines furnished in conjunction with screening colonoscopy services with modifier PT

Codes	
CPT code section	
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). Additional base units are not allowed. (Per the ASA RVG® an additional unit for 99100 is not allowed with anesthesia codes 00326, 00561, 00834 and 00836)
99116	Anesthesia complicated by utilization of total body hypothermia (List separately in addition to code for primary anesthesia procedure). Additional base units are not allowed. (Per the ASA RVG® additional units for 99116 are not allowed with anesthesia codes 00561, 00562, 00563, 00566, and 00567)
99135	Anesthesia complicated by utilization of controlled hypotension (List separately in addition to code for primary anesthesia procedure). Additional base units are not allowed. (Per the ASA RVG® additional units for 99135 are not allowed with anesthesia codes 00561, 00562, 00563, 00566, and 00567)
99140	Anesthesia complicated by emergency conditions (specify) (List separately in addition to code for primary anesthesia procedure) Additional base units are not allowed. (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.)

Modifier Codes		
Code	**Description**	**Reimbursement Percentage**
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.	
AA	Anesthesia services performed personally by an anesthesiologist.	100%

AD	Medical supervision by a physician: more than four concurrent anesthesia procedures. *For additional information, refer to Standard Anesthesia Formula with Modifier AD under Reimbursement Formula	100%
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals.	50%
QX	Qualified nonphysician anesthetist with medical direction by a physician	50%
QY	Medical direction of one qualified nonphysician anesthetist by an anesthesiologist	50%
QZ	CRNA service; without medical direction by a physician.	100%
Physical Status Modifiers	CPT and ASA guidelines identify six levels of ranking for patient physical status. CMS does not allow additional reimbursement units for these codes.	Reimbursement
P1	A physical status modifier for a normal healthy patient.	**No additional-** This is considered an informational
P2	A physical status modifier for a patient with mild systemic disease.	
P3	A physical status modifier for a patient with severe systemic disease.	
P4	A physical status modifier for a patient with severe systemic disease that is a constant threat to life.	
P5	A physical status modifier for a moribund patient who is not expected to survive without the operation.	
P6	A physical status modifier for a declared brain-dead patient whose organs are being removed for donor purposes.	
Informational Modifiers	If reporting CPT modifier 23 or 47 or HCPCS modifier GC, G8, G9, PT or QS then no additional reimbursement is allowed above the usual fee for that service.	Reimbursement
23	Unusual Anesthesia	**No additional-** This is considered an informational modifier only.
47	Anesthesia by Surgeon	
GC	This service has been performed in part by a resident under the direction of a teaching physician	
G8	Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure	**No additional –** 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.
G9	Monitored anesthesia care (MAC) for patient who has a history of severe cardiopulmonary condition	
PT	Colorectal cancer screening test; converted to diagnostic test or other procedure	
QS	Monitored anesthesiology care services (can be billed by a qualified nonphysician anesthetist or a physician)	

Resources

www.cms.gov

American Medical Association (AMA) 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

History	
08/12/2020	• Updated Policy Number from 2019R9008B to 2020R9008B • Reimbursement Guidelines Correction ○ Removed reference to “attached procedure code list” from reimbursement guidelines section. There is no attached procedure code list within this policy.
10/31/2019	Policy Update (new version) • Application Section • Definitions Section
10/1/2019	Policy Update (new version) • Clarifying statement under the Time Reporting section added

2/1/2019	Annual Anniversary Date and Version Change
	• Policy template updated
	  ○ Preamble section updated
	  ○ Title section updated
	• Overview section updated
	  ○ Moderate Sedation Overview removed
	• Definitions section updated
	• Q&A section updated
	• Codes Section updated
	• Modifier Codes updated
	• Archived history prior to 2/1/2017

9/7/2018	• Policy number changed to 2018R9008A (new version) • Title change to add Professional • Archive history prior to 9/1/2016
7/10/2018	Definition Correction (no new version)
3/14/2018	Annual Review • Version Change • History prior to 1/1/2016 archived • Resource list updated
12/29/2017	Version Change • Updated to Word 2010 format • Preamble update • Replaced deleted moderate sedation codes with new codes • Removed Appendix G instructions due to the removal in the CPT code book • Updated Resource Section
7/12/2017	Annual Review (no new version)
8/27/2014	New Policy

