UnitedHealthcare®
Oxford

ANESTHESIA POLICY (CES)

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Related Policies

- Refer to the Reimbursement Guidelines section of the policy

INSTRUCTIONS FOR USE

The services described in Oxford policies are subject to the terms, conditions and limitations of the member's contract or certificate. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members. Oxford reserves the right, in its sole discretion, to modify policies as necessary without prior written notice unless otherwise required by Oxford's administrative procedures or applicable state law. The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies.

Certain policies may not be applicable to Self-Funded members and certain insured products. Refer to the member specific benefit plan document or Certificate of Coverage to determine whether coverage is provided or if there are any exclusions or benefit limitations applicable to any of these policies. If there is a difference between any policy and the member specific benefit plan document or Certificate of Coverage, the member specific benefit plan document or Certificate of Coverage will govern.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

APPLICABLE LINES OF BUSINESS/PRODUCTS

This policy applies to Oxford Commercial plan membership.

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 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.

OVERVIEW

Oxford'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.

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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 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, Oxford will adjust the Allowed Amount by the Modifier Percentage indicated in the table below.

Required Anesthesia Modifiers	Reimbursement Percentage
AA	100%
AD	100%
QK	50%
QX	50%
QY	50%
QZ	100%

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.

Physical Status Modifiers	Modifying Units Added to the Base Unit Value
P1	0 units
P2	0 units
P3	1 unit
P4	2 units
P5	3 units

Other Modifiers: These CPT and HCPCS modifiers may be reported to identify an altered circumstance for anesthesia and pain management. 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.

CPT Modifiers	HCPCS Modifiers
22	GC
23	G8
47	G9
59	QS
76	XE
77	XP
78	XS
79	XU

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Reimbursement Formula

Base Values: Each CPT anesthesia code (00100-01999) is assigned a Base Value by the ASA, and Oxford 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, Oxford 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.

CPT Code	Qualifying Circumstance	Modifying Units
99100	Per the ASA RVG® an additional unit for 99100 is not allowed with anesthesia codes 00326, 00561, 00834 and 00836	1 unit
99116	Per the ASA RVG® additional units for 99116 are not allowed with anesthesia codes 00561, 00562, 00563 and 00567	5 units
99135	Per the ASA RVG® additional units for 99135 are not allowed with anesthesia codes 00561, 00562, 00563 and 00567	5 units
99140	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	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. Oxford 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, Oxford 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.

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In the event an anesthesia administration service is provided during a different operative session on the same day as a previous operative session, Oxford 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.

Anesthesia and Procedural Bundled Services

Oxford 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 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 Oxford *Reimbursement for Comprehensive and Component CPT Codes* 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: 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: 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."

Oxford 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 Applicable Codes 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.

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Preoperative/Postoperative Visits

Consistent with CMS, Oxford 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.

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® Oxford 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).

Obstetric Add-On Codes

Obstetric Anesthesia often involves extensive hours and the transfer of anesthesia to a second physician. Due to these unique circumstances, Oxford 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

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.

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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. For non-network physicians the applied Conversion Factor is based on a recognized national source.

Definitive Source: Definitive Sources contain the exact codes, modifiers or very specific instructions from the given source.

Interpretive Source: 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.

Moderate Sedation: 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).

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).

Modifying Units: 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).

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.

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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, Oxford requires time-based anesthesia services be reported with actual Anesthesia Time in one-minute increments.

QUESTIONS AND ANSWERS

#		
1	Q:	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?
	A:	For general or monitored anesthesia services in support of a non-anesthesia service, refer to the ASA Crosswalk® and report the appropriate CPT anesthesia code (00100 - 01999).
2	Q:	How should anesthesia services performed by the same physician who also furnishes the medical or surgical procedure be reported?
	A:	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.
3	Q:	How should anesthesia services be reported when surgery has been cancelled?
	A:	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 & 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.
4	Q:	How should a CRNA report anesthesia services?
	A:	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 Oxford, CRNA services must be reported under the CRNA's name.
5	Q:	How should a teaching anesthesiologist report anesthesia services for two resident cases?
	A:	Consistent with CMS policy, the teaching anesthesiologist may report the actual Anesthesia Time (see definitions) for each case with modifiers AA and GC.
6	Q:	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?
	A:	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.
7	Q:	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?
	A:	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).
8	Q:	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?
	A:	Oxford 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.

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Q: Will anesthesia services submitted with modifier 22 qualify for additional reimbursement?

A: 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. Modifier 22 reimbursement for anesthesia services with a Base Unit Value less than 5 occurs within the Standard Anesthesia Formula by adding additional base units so that the total base units = 5.

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.

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Q: What is the best approach to take to submit supporting documentation for modifier 22?

A: Submit a paper claim using the CMS form accompanied by the requested documentation.

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Q: 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?

A: The 1500 Health Insurance Claim Form Reference Instruction Manual located at www.nucc.org provides the following instructions:

Paper Claims with CMS Paper Format 02-12: item number 24G titled Days or Units [lines 1–6] should be completed as follows:

- 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.
- Enter numbers left justified in the field. No leading zeros are required. If reporting a fraction of a unit, use the decimal point.
- Anesthesia services must be reported as minutes. Units may only be reported for anesthesia services when the code description includes a time period (such as "daily management").

Electronic Claims: 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.

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

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: www.nucc.org

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Q: 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?

A: Oxford 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.

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Q: What guidelines are available for reporting anesthesia teaching services?

A: Information on reporting anesthesia teaching services is available in the Department of Health and Human Services *Federal Register* publication, November 25, 2009 edition, page 61867. A link to the *Federal Register* is located in the References section.
Note that reimbursement for anesthesia services is based on the specific modifier reported. Refer to the Reimbursement Formula and Modifiers sections.

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Q: 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?

A: According to ASA RVG®, the use of a brain function monitor for intraoperative awareness is not separately reportable in conjunction with an anesthetic service.

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	Q:	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?
	A:	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.

APPLICABLE CODES

CPT Codes										
Anesthesia Codes Identifies codes that are considered anesthesia (base + time) services.										
00100	00102	00103	00104	00120	00124	00126	00140	00142	00144	00145
00147	00148	00160	00162	00164	00170	00172	00174	00176	00190	00192
00210	00211	00212	00214	00215	00216	00218	00220	00222	00300	00320
00322	00326	00350	00352	00400	00402	00404	00406	00410	00450	00454
00470	00472	00474	00500	00520	00522	00524	00528	00529	00530	00532
00534	00537	00539	00540	00541	00542	00546	00548	00550	00560	00561
00562	00563	00566	00567	00580	00600	00604	00620	00625	00626	00630
00632	00635	00640	00670	00700	00702	00730	00731	00732	00750	00752
00754	00756	00770	00790	00792	00794	00796	00797	00800	00802	00811
00812	00813	00820	00830	00832	00834	00836	00840	00842	00844	00846
00848	00851	00860	00862	00864	00865	00866	00868	00870	00872	00873
00880	00882	00902	00904	00906	00908	00910	00912	00914	00916	00918
00920	00921	00922	00924	00926	00928	00930	00932	00934	00936	00938
00940	00942	00944	00948	00950	00952	01112	01120	01130	01140	01150
01160	01170	01173	01200	01202	01210	01212	01214	01215	01220	01230
01232	01234	01250	01260	01270	01272	01274	01320	01340	01360	01380
01382	01390	01392	01400	01402	01404	01420	01430	01432	01440	01442
01444	01462	01464	01470	01472	01474	01480	01482	01484	01486	01490
01500	01502	01520	01522	01610	01620	01622	01630	01634	01636	01638
01650	01652	01654	01656	01670	01680	01710	01712	01714	01716	01730
01732	01740	01742	01744	01756	01758	01760	01770	01772	01780	01782
01810	01820	01829	01830	01832	01840	01842	01844	01850	01852	01860
01916	01920	01922	01924	01925	01926	01930	01931	01932	01933	01935
01936	01951	01952	01958	01960	01961	01962	01963	01965	01966	01967
01968	01969	01990	01991	01992	01999					

CPT Codes										
Evaluation and Management Codes Bundled into Anesthesia Identifies Evaluation and Management codes considered to be included in the Base Unit Value for the anesthesia service.										
99421	99422	99423	99458	99473	99474	92002	92004	92012	92014	99091
99201	99202	99203	99204	99205	99211	99212	99213	99214	99215	99217
99218	99219	99220	99221	99222	99223	99224	99225	99226	99231	99232
99233	99234	99235	99236	99238	99239	99241	99242	99243	99244	99245
99251	99252	99253	99254	99255	99281	99282	99283	99284	99285	99288
99304	99305	99306	99307	99308	99309	99310	99315	99316	99318	99324

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CPT Codes										
Evaluation and Management Codes Bundled into Anesthesia Identifies Evaluation and Management codes considered to be included in the Base Unit Value for the anesthesia service.										
99325	99326	99327	99328	99334	99335	99336	99337	99339	99340	99341
99342	99343	99344	99345	99347	99348	99349	99350	99354	99355	99356
99357	99358	99359	99360	99366	99367	99368	99374	99375	99377	99378
99379	99380	99381	99382	99383	99384	99385	99386	99387	99391	99392
99393	99394	99395	99396	99397	99401	99402	99403	99404	99406	99407
99408	99409	99411	99412	99415	99416	99429	99441	99442	99443	99444
99446	99447	99448	99449	99450	99451	99452	99453	99454	99455	99456
99457	99460	99461	99462	99463	99464	99465	99466	99467	99468	99469
99471	99472	99475	99476	99477	99478	99479	99480	99483	99484	99487
99489	99490	99491	99492	99493	99494	99495	99496	99497	99498	99499

CPT Codes										
Procedural or Pain Management Codes Bundled into Anesthesia Identifies codes included in the Base Unit Value for the anesthesia service.										
0213T	0214T	0215T	0216T	0217T	0218T	0228T	0229T	0230T	0231T	36415
36416	36591	36592	43755	62320	62321	62322	62323	62324	62325	62326
62327	64400	64402	64405	64408	64410	64413	64415	64416	64417	64418
64420	64421	64425	64430	64435	64445	64446	64447	64448	64449	64450
64461	64462	64463	64479	64480	64483	64484	64486	64487	64488	64489
64490	64491	64492	64493	64494	64495	64505	64510	64517	64520	64530
64561	80345	81001	81007	82270	82271	82800	82803	82805	82810	85345
85347	85348	94005	95941	99050	99051	99053	99056	99058	99060	

CPT Codes										
Procedural or Pain Management Bundled Codes Allowed with Modifiers 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 anesthesia service on the same date of service.										
0213T	0214T	0215T	0216T	0217T	0218T	0228T	0229T	0230T	0231T	36415
36416	43755	62320	62321	62322	62323	62324	62325	62326	62327	64400
64402	64405	64408	64410	64413	64415	64416	64417	64418	64420	64421
64425	64430	64435	64445	64446	64447	64448	64449	64450	64461	64462
64463	64479	64480	64483	64484	64486	64487	64488	64489	64490	64491
64492	64493	64494	64495	64505	64510	64517	64520	64530	64561	80345
81001	81007	82270	82271	82800	82803	82805	82810	85345	85347	85348

HCPCS Code	Crosswalk Code	HCPCS Code	Crosswalk Code	HCPCS Code	Crosswalk Code	HCPCS Code	Crosswalk Code	HCPCS Code	Crosswalk Code
Anesthesia Services Bundled into HCPCS Procedural Codes Identifies medical/surgical procedures reported as HCPCS codes and their direct or alternate crosswalk anesthesia codes.									
G0104	00812	G0105	00812	G0121	00812	G0186	00140	G0186	00145
G0268	00124	G0339	01922	G0340	01922	G0341	00700	G0341	00790
G0342	00790	G0343	00790	G0412	01120	G0413	01120	G0414	00170
G0414	01120	G0415	00170	G0415	01120	G0429	00300	G0516	00400
G0517	00400	G0518	00400	G6003	01922	G6004	01922	G6005	01922
G6006	01922	G6007	01922	G6008	01922	G6009	01922	G6010	01922

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HCPCS Code	Crosswalk Code	HCPCS Code	Crosswalk Code	HCPCS Code	Crosswalk Code	HCPCS Code	Crosswalk Code	HCPCS Code	Crosswalk Code
Anesthesia Services Bundled into HCPCS Procedural Codes Identifies medical/surgical procedures reported as HCPCS codes and their direct or alternate crosswalk anesthesia codes.									
G6011	01922	G6012	01922	G6013	01922	G6014	01922	G6015	01922
G6016	01922	G6017	01922	S0601	00902	S0800	00140	S0800	00142
S0810	00140	S0810	00142	S0812	00140	S0812	00142	S2053	00790
S2054	00790	S2060	00540	S2060	00541	S2060	00580	S2061	00540
S2061	00541	S2061	00580	S2065	00868	S2066	00402	S2067	00402
S2068	00402	S2070	00918	S2079	00500	S2079	00790	S2080	00170
S2095	01924	S2095	01925	S2095	01926	S2095	01930	S2102	00700
S2102	00790	S2103	00210	S2112	01400	S2115	01120	S2115	01210
S2117	01480	S2118	01210	S2205	00561	S2205	00562	S2205	00563
S2205	00566	S2205	00567	S2206	00561	S2206	00562	S2206	00563
S2206	00566	S2206	00567	S2207	00561	S2207	00562	S2207	00563
S2207	00566	S2207	00567	S2208	00561	S2208	00562	S2208	00563
S2208	00566	S2208	00567	S2209	00561	S2209	00562	S2209	00563
S2209	00566	S2209	00567	S2225	00126	S2230	00120	S2235	00210
S2260	01966	S2265	01966	S2266	01966	S2267	01966	S2300	01630
S2325	01210	S2340	00300	S2340	00326	S2341	00300	S2341	00326
S2342	00160	S2348	00640	S2348	01936	S2350	00630	S2400	00800
S2401	00800	S2402	00800	S2403	00800	S2404	00800	S2405	00800
S4028	00920								

REFERENCES

The foregoing Oxford policy has been adapted from an existing UnitedHealthcare national policy that was researched, developed and approved by UnitedHealthcare Reimbursement Policy Oversight Committee. [*2020R0032C*]

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

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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

POLICY HISTORY/REVISION INFORMATION

Date	Action/Description
08/01/2020	**Questions and Answers (Q&A)** • Updated A #9 pertaining to reimbursement for anesthesia services submitted with modifier 22 • Archived previous policy version ADMINISTRATIVE 269.2 T0

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