

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.

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.

Required Anesthesia Modifiers	Reimbursement Percentage	Provider type
AA	100%	Anesthesiologist MD Personally Performed
AD	100%	Anesthesiologist MD Supervising over 4
QK	50%	Anesthesiologist MD Supervising 2-4
QX	50%	CRNA or AA Directed by Anesthesiologist MD
QY	50%	Anesthesiologist MD Supervising 1
QZ	100%	CRNA Personally Performed

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

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

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		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.

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.

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:

Procedural or Pain Management Codes Bundled into Anesthesia

0213T	0214T	0215T	0216T	0217T	0218T	36415	36416	36591	36592
43755	62320	62321	62322	62323	62324	62325	62326	62327	64400
64405	64408	64415	64416	64417	64418	64420	64421	64425	64430
64435	64445	64446	64447	64448	64449	64450	64451	64454	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								

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

0213T	0214T	0215T	0216T	0217T	0218T	36415	36416	43755	62320
62321	62322	62323	62324	62325	62326	62327	64400	64405	64408
64415	64416	64417	64418	64420	64421	64425	64430	64435	64445
64446	64447	64448	64449	64450	64451	64454	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								

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.

Anesthesia Services Bundled into HCPCS Procedural Codes

G0104 00812	G0105 00812	G0121 00812	G0186 00140
G0186 00145	G0268 00124	G0297 01922	G0339 01922
G0340 01922	G0341 00700	G0341 00790	G0342 00790
G0343 00790	G0412 01120	G0413 01120	G0414 00170
G0414 01120	G0415 00170	G0415 01120	G0428 01400
G0429 00300	G0448 00534	G0516 00400	G0517 00400
G0518 00400	G2170 01844	G2171 01844	G6003 01922
G6004 01922	G6005 01922	G6006 01922	G6007 01922
G6008 01922	G6009 01922	G6010 01922	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	S2348 01942	S2350 00630
S2400 00800	S2401 00800	S2402 00800	S2403 00800
S2404 00800	S2405 00800	S4028 00920	

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; CPT codes 99091, 99202-99499 (excluding critical care CPT codes 99291-99292) and 92004-92014 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 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	
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. 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: <ul style="list-style-type: none"> • Diagnosis and treatment of clinical problems that occur during the procedure

	<ul style="list-style-type: none"> • 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. <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>
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	<p>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?</p> <p>A: 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>
2	<p>Q: How should anesthesia services performed by the same physician who also furnishes the medical or surgical procedure be reported?</p> <p>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.</p>
3	<p>Q: How should anesthesia services be reported when surgery has been cancelled?</p> <p>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.</p>
4	<p>Q: How should a CRNA report anesthesia services?</p> <p>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 UnitedHealthcare, CRNA services must be reported under the CRNA's name.</p>
5	<p>Q: How should a teaching anesthesiologist report anesthesia services for two resident cases?</p> <p>A: Consistent with CMS policy, the teaching anesthesiologist may report the actual Anesthesia Time (see definitions) for each case with modifiers AA and GC.</p>

6	<p>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?</p> <p>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.</p>
7	<p>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?</p> <p>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).</p>
8	<p>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?</p> <p>A: 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>
9	<p>Q: Will anesthesia services submitted with modifier 22 qualify for additional reimbursement?</p> <p>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.</p> <p>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.</p>
10	<p>Q: What is the best approach to take to submit supporting documentation for modifier 22?</p> <p>A: Submit a paper claim using the CMS form accompanied by the requested documentation.</p>
11	<p>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?</p> <p>A: The 1500 Health Insurance Claim Form Reference Instruction Manual located at www.nucc.org provides the following instructions:</p> <p>Paper Claims with CMS Paper Format 02-12: item number 24G titled Days or Units [lines 1–6] should be completed as follows:</p> <ul style="list-style-type: none"> • 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 <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”). <p>Electronic Claims: Below is a crosswalk of the 02-12 version 1500 Health Care Claim Form (1500 Claim Form) to</p>

<p>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>		
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
<p>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</p>		
12	<p>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?</p> <p>A: 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>	
13	<p>Q: What guidelines are available for reporting anesthesia teaching services?</p> <p>A: 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 Resources section.</p> <p>Note that reimbursement for anesthesia services is based on the specific modifier reported. Refer to the Reimbursement Formula and Modifiers sections.</p>	
14	<p>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?</p> <p>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.</p>	
15	<p>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?</p> <p>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.</p>	

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)

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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

5/15/2022	Policy Version Change Updated Anesthesia Services Bundled into HCPCS Procedural Codes list History Section: Entries prior to 5/15/2020 archived
7/19/2021	Policy Version Change Anesthesia Services: Removed reference to list Preoperative/Postoperative Visits: Added range of Evaluation and Management codes Procedural or Pain Management Codes Bundled into Anesthesia Services: Added tables Attachments Section: Removed attachment(s) and converted to table(s)
6/1/2021	Policy Version Change Modifiers Section: Added Provider Type column to Required Anesthesia Modifiers Grid History Section: Entries prior to 6/1/2019 archived
1/1/2021	Policy Version Change 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 History Section: Entries prior to 1/1/2019 archived
11/8/2020	Policy Version Change Attachments: Updated Anesthesia Services Bundled into HCPCS Procedural Codes list
5/28/2020	Policy Version Change Questions and Answers: Updated Q&A #9
8/17/2004	Policy implemented by UnitedHealthcare Employer & Individual
2/10/1999	Policy approved by Clinical Review Committee