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 Community Plan reimbursement policies uses 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 Community Plan's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Community Plan 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 Community Plan enrollees.

Other factors affecting reimbursement supplement, modify or, in some cases, supersede this policy. These factors include, but are not limited to: federal &/or state regulatory requirements, 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 Community Plan due to programming or other constraints; however, UnitedHealthcare Community Plan strives to minimize these variations.

UnitedHealthcare Community Plan 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 UnitedHealthcare Community Plan Medicaid products.

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 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 Community Plan'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 Community Plan will adjust the Allowed Amount by the Modifier Percentage indicated in the table below. (See State Exceptions section for state specifics that may vary)

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

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

Reimbursement Formula

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

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 Community Plan 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 Community Plan 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 Community Plan 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 Community Plan 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 Community Plan "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 Pain 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 table that will be considered distinct procedural services when modifier 59, XE or XU is appended, refer to the table below.

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 Community Plan will not separately reimburse an anesthesia service when reported with a medical or surgical procedure (where the anesthesia service is the 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

Code1	Code2	Code1	Code2	Code1	Code2	Code1	Code2
G0104	00812	G6010	01922	S2095	01924	S2208	00567
G0105	00812	G6011	01922	S2095	01925	S2209	00561
G0121	00812	G6012	01922	S2095	01926	S2209	00562
G0186	00140	G6013	01922	S2095	01930	S2209	00563
G0186	00145	G6014	01922	S2102	00700	S2209	00566
G0268	00124	G6015	01922	S2102	00790	S2209	00567
G0339	01922	G6016	01922	S2103	00210	S2225	00126
G0340	01922	G6017	01922	S2112	01400	S2230	00120
G0341	00700	S0601	00902	S2115	01120	S2235	00210
G0341	00790	S0800	00140	S2115	01210	S2260	01966
G0342	00790	S0800	00142	S2117	01480	S2265	01966
G0343	00790	S0810	00140	S2118	01210	S2266	01966
G0412	01120	S0810	00142	S2205	00561	S2267	01966
G0413	01120	S0812	00140	S2205	00562	S2300	01630
G0414	00170	S0812	00142	S2205	00563	S2325	01210
G0414	01120	S2053	00790	S2205	00566	S2340	00300
G0415	00170	S2054	00790	S2205	00567	S2340	00326
G0415	01120	S2060	00540	S2206	00561	S2341	00300
G0428	01400	S2060	00541	S2206	00562	S2341	00326
G0429	00300	S2060	00580	S2206	00563	S2342	00160
G0448	00534	S2061	00540	S2206	00566	S2348	00640
G0516	00400	S2061	00541	S2206	00567	S2348	01942
Code1	**Code2**	**Code1**	**Code2**	**Code1**	**Code2**	**Code1**	**Code2**
G0517	00400	S2061	00580	S2207	00561	S2350	00630
G0518	00400	S2065	00868	S2207	00562	S2400	00800

G6003	01922		S2066	00402		S2207	00563		S2401	00800
G6004	01922		S2067	00402		S2207	00566		S2402	00800
G6005	01922		S2068	00402		S2207	00567		S2403	00800
G6006	01922		S2070	00918		S2208	00561		S2404	00800
G6007	01922		S2079	00500		S2208	00562		S2405	00800
G6008	01922		S2079	00790		S2208	00563		S4028	00920
G6009	01922		S2080	00170		S2208	00566			

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 on crosswalk codes.

Preoperative/Postoperative Visits
Consistent with CMS, UnitedHealthcare Community Plan 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 Community Plan will reimburse neuraxial labor analgesia (CPT code 01967) based on Base Unit Value plus Time Units.

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 Community Plan will consider for reimbursement add-on CPT codes 01968 and 01969 when reported by the same or different individual physician or healthcare professional than reported the primary CPT code 01967 for services rendered to the same individual 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.

State Exceptions	
Arizona	Per state regulations, modifier AD reimburses at 50% of the allowed amount.

California	Per State Regulations, • CA allows reimbursement for Modifier 47. • The AD modifier is not an approved modifier for CA Medicaid.
Florida	Per state regulations, • Reimbursement for modifier QK and QY is 20%. • Reimbursement for modifier QX and QZ is 80%. • Epidural Anesthesia Codes 01967 and 01967 + 01968 must be limited to pay no more than 360 minutes (24 units) for a vaginal or cesarean delivery.
Indiana	Per state regulations: • Modifiers can be appended in any position for the state of Indiana. Services should be billed with the appropriate CPT code and a physical status modifier corresponding to the status of the member undergoing the procedure. • Reimbursement for modifier QZ is 60%. • Reimbursement for modifier QX is 30% • Claim lines appended with a QY modifier will be denied. • Reimbursement for postoperative epidural catheter management services using CPT code 01996. The state does not pay separately for CPT code 01996 on the same day the epidural is placed. Rather, providers should bill this code on subsequent days when the epidural is actually being managed. • Altered circumstance for anesthesia and pain management does not apply to Indiana. • For CPT codes 01960 and 01967, one time unit allowed for each 15-minute block of time billed in the first hour of service and, for subsequent hours of service, one unit of service is allowed for every 60-minute block of time or portion billed.
Kansas	Per State Regulations, • Only direct face to face time is reimbursable • Modifier AD is not covered by KMAP • CPT codes 01990 and 01996 can be billed with or without an anesthesia modifier • CPT code 01953 is required to be billed with an anesthesia modifier
Minnesota	Per the state of MN regulations, anesthesia modifiers QK, QY, and QX will be reimbursed according to the rates published on the state website.
Missouri	Anesthesia modifiers are reimbursed according to the fee schedule. Missouri will not follow reimbursement policy reductions. State has specific FS for modifier and a specific conversion factor. Modifier AD & QY are not reimbursable (not covered on fee schedules).
Nebraska	Pays “Q” modifiers based on a conversion factor rather than a percentage
New York	Per New York Medicaid state regulations, Modifier QZ is not reimbursable. Per state regulations: Administration of a nerve block (either as a component of the anesthesia itself or a postoperative pain management protocol) is considered part of the anesthesia time for surgery. This will not be reimbursed as a separate and distinct procedural service when performed by the same provider (or his/her associate) that has provided the anesthesia for the surgical procedure itself. Post op visits are included in the total value for anesthesia services
Rhode Island	• Par Anesthesia providers are required to bill with ASA codes • Non Par Anesthesia providers are required to bill the same code as the primary surgeon, not ASA codes. Only one unit will be allowed and surgical codes are not reimbursed as time units. • Non Par Anesthesiologists claims are reimbursed 25% of the surgeon’s fee schedule.

Texas	Reimbursement for modifiers AA, AD, QK & QY is 100% Reimbursement for modifiers QZ & QX is 92% Texas requires the addition of a U1 or U2 modifier to be billed in addition to an anesthesia modifier AA, AD, QK, QX, QY, and QZ: "U" modifier may be in any position. AA plus U1 AD plus U1 OR U2 QK plus U1 or U2 QX plus U2 QY plus U1 or U2 QZ plus U1 (Source: https://www.tmhp.com/sites/default/files/file-library/resources/provider-manuals/tmppm/pdf-chapters/2020/2020-10-october/1_06_Claims_Filing.pdf) If a required "U" modifier is not present in any position when a qualifying anesthesia code is billed with an AA, AD, QK, QX, QY, or QZ modifier is billed, the claim should deny for missing modifier.
Washington DC	Per state regulations, modifier AD reimburses at 35% of the allowed amount.
Wisconsin	Wisconsin Medicaid consider 01996 to be an anesthesia service and requires modifiers AA, AD, QK, QS, QX, QY or QZ. Modifiers are reimbursed based on a per unit rate rather than a percentage. Modifiers AA, AD = $17.75 Modifier QK = $7.75 Modifier QX = $10.84 Modifier QY = $9.68 Modifier QZ = $16.00

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 Allowable Amounts, whichever is applicable. For percent of charge or discount contracts, the Allowable Amount is determined as the billed amount, less the discount.
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.
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.
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.
Basic 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 a very specific instruction from a 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 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).
Monitored Anesthesia Care	Per the ASA Monitored Anesthesia Care includes all aspects of anesthesia care – a pre-procedure visit, intra-procedure care and post-procedure 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:** 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, please 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 UnitedHealthcare Community Plan, 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 or 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 an Anesthesia Assistant (AA) for an anesthesia service, how should the service for the AA and the supervising physician be reported? **A:** UnitedHealthcare Community Plan 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.
8	**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:

<table>
<tr><td></td><td>

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.
<table>
<tr><th>1500 form</th><th>837P</th><th>Notes</th></tr>
<tr><th>Item Number/Title</th><th>Loop ID/Segment Data Element</th><th></th></tr>
<tr><td>24G/Days or Units</td><td>2400/SV104</td><td>Titled Service Unit Count in the 837P</td></tr>
</table>
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
</td></tr>
<tr><td>9</td><td>
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 Resources 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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<tr><td>10</td><td>
Q: The policy states to submit supporting documentation. What is the best approach to take?
A: Submit a paper claim using the CMS form accompanied by the requested documentation.
</td></tr>
<tr><td>11</td><td>
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.
</td></tr>
<tr><td>12</td><td>
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.
</td></tr>
</table>

Resources

American Medical Association, *Current Procedural Terminology (*CPT®) and associated publications and services

American Society of Anesthesiologists, Relative Value Guide®

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services

Centers for Medicare and Medicaid Services, National Correct Coding Initiative (NCCI) publications
Centers for Medicare and Medicaid Services, Physician Fee Schedule (PFS) Relative Value Files

National Uniform Claim Committee (NUCC)

Publications and services of the American Society of Anesthesiologists (ASA)

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

History	
6/21/2024	Policy Version Change State Exceptions section: Wisconsin updated History section: Entries prior to 6/21/2022 archived
12/1/2023	Policy Version Change State Exceptions section: Kansas updated History section: Entries prior to 12/1/2021 archived
4/21/2023	Policy Version Change State Exceptions section: Minnesota updated History section: Entries prior to 4/21/2021 archived
2/26/2023	Policy Version Change State Exceptions section: Kentucky removed
2/1/2023	Policy Year and Version Change Reimbursement Guidelines: Anesthesia Services Bundled into HCPCS Procedural Codes table updated History section: Entries prior to 2/1/2021 archived
3/25/2006	Policy Implemented by UnitedHealthcare Community & State