

Anesthesia Policy, Professional for Louisiana

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.

*CPT Copyright American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association.

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.

Table of Contents

[Application](#)

[Policy](#)

[Overview](#)

[Reimbursement Guidelines](#)

[Anesthesia Services](#)

[Modifiers](#)

[Reimbursement Formula](#)

[Multiple or Duplicate Anesthesia Services](#)

[Anesthesia and Procedural Bundled Services](#)

[Daily Hospital Management](#)

[Obstetric Anesthesia Services](#)

[Definitions](#)

[Questions and Answers](#)

[Attachments](#)

[Resources](#)

[History](#)

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.

All services described in this policy may be subject to additional UnitedHealthcare Community Plan reimbursement policies including but not limited to the "CCI Editing Policy." Refer to UnitedHealthcare Community Plan's "Add-on Policy" for further details on reimbursement of CPT code 01953.

Reimbursement Guidelines

Anesthesia Services

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

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

Modifiers

| Required Anesthesia Modifiers | All services reported for anesthesia management services must be submitted with the appropriate HCPCS modifiers. These modifiers identify monitored anesthesia and whether a procedure was personally performed, medically directed, or medically supervised. Consistent with CMS, UnitedHealthcare Community Plan will adjust the allowance by the modifier percentage indicated in the table below. (see attachment State Variances Section for state specifics that may vary) | Reimbursement Percentage |
|-------------------------------|--|--------------------------|
| AA | Anesthesia services performed personally by an anesthesiologist. | 100% |
| AD | Medical supervision by a physician: more than four concurrent anesthesia procedures. *For additional information, refer to Standard Anesthesia Max with Modifier AD under Reimbursement Formula | 100% |
| G8 | Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure | |
| G9 | Monitored anesthesia care (MAC) for patient who has a history of severe cardiopulmonary condition | |
| QK | Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals. | 50% |
| QX | Qualified non-physician anesthetist with medical direction by a physician | 50% |
| QY | Medical direction of one qualified non-physician anesthetist by an anesthesiologist | 50% |
| QZ | CRNA service; without medical direction by a physician. | 100% |

| Other Modifiers | These CPT modifiers may be reported to identify an altered circumstance for anesthesia and pain management. | Additional Information |
|-------------------------|--|--|
| 22 | Increased Procedural Services | See Questions and Answers section, Q&A #8. |
| 59 | Distinct Procedural Service | |
| 76 | Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional | |
| 77 | Repeat Procedure by Another Physician or Other Qualified Health Care Professional | |
| 78 | Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period | |
| 79 | Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period | |
| XE | Separate encounter: a service that is distinct because it occurred during a separate encounter. | |
| XU | Unusual non-overlapping service: the use of a service that is distinct because it does not overlap usual components of the main service. | |
| Informational Modifiers | If reporting CPT modifier 23 or 47 or HCPCS modifier GC, G8, G9 or QS then no additional reimbursement is allowed above the usual fee for that service. | Reimbursement |
| 23 | Unusual Anesthesia | No additional- This is considered an informational modifier only. For CPT 00170, Modifier 23 allows an additional \$20 per time unit |
| 47 | Anesthesia by Surgeon | No additional - This is considered an informational modifier only. |
| GC | This service has been performed in part by a resident under the direction of a teaching physician | No additional - This is considered an informational modifier only. |
| QS | Monitored anesthesia care services (can be billed by a qualified non-physician anesthetist or a physician) | No additional – This is considered an informational modifier only which should be billed along with a required anesthesia modifier and not be in the first modifier position |
| XP | Separate practitioner: a service that is distinct because it was performed by a different practitioner | |
| XS | Separate structure: a service that is distinct because it was performed on a separate organ/structure | |

Reimbursement Formula

Base Values:

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

For additional information on reporting Anesthesia Time, refer to the Definitions and [Questions and Answers Q&A #7](#) sections.

Reimbursement Formulas:

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

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

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

*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. Specific reimbursement percentages are based on the anesthesia modifier(s) reported.

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.

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

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 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."

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 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 the interpretive edits titled "Anesthesia Services Bundled into HCPCS Procedural Codes" can be found in the Attachments section below.

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

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

Preoperative/Postoperative Visits

Consistent with CMS, UnitedHealthcare Community Plan 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 (outpatient hospital) 21 (inpatient hospital), 22 (outpatient hospital) or 25 (birthing center) is a separately reimbursable service once per date of service excluding the day of insertion. CPT code 01996 is considered included in the pain management procedure if submitted on the same date of service by the Same Individual Physician or Other Qualified Health Care Professional.

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

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 management 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.

State Exceptions

| | | | | | | | | | |
|----------------------------|--|--------------------|------------------------------------|----------------------------|-----------|--------------------|------------------------------------|----------------------------|---|
| Louisiana | <p>Louisiana (LA) Medicaid allows reimbursement for a shared obstetric (OB) anesthesia service when the introduction of the anesthesia and the monitoring of the anesthesia are performed by different individual providers (same or different TIN). Claims for CPT codes 01961, 01967, and/or 01968 appended with the specified modifiers in the first and second positions, as shown below, should not deny as duplicate.</p> <p>A claim for Introduction Only by Anesthesiologist</p> <table border="0"> <tr> <td>CPT Procedure Code</td> <td>Modifiers required (in this order)</td> </tr> <tr> <td>01961, 01967, and/or 01968</td> <td>AA and 52</td> </tr> </table> <p>AND</p> <p>Another claim for Monitoring by Anesthesiologist or CRNA</p> <table border="0"> <tr> <td>CPT Procedure Code</td> <td>Modifiers required (in this order)</td> </tr> <tr> <td>01961, 01967, and/or 01968</td> <td>AA and QS or QZ and QS or QX and QS</td> </tr> </table> | CPT Procedure Code | Modifiers required (in this order) | 01961, 01967, and/or 01968 | AA and 52 | CPT Procedure Code | Modifiers required (in this order) | 01961, 01967, and/or 01968 | AA and QS or QZ and QS or QX and QS |
| CPT Procedure Code | Modifiers required (in this order) | | | | | | | | |
| 01961, 01967, and/or 01968 | AA and 52 | | | | | | | | |
| CPT Procedure Code | Modifiers required (in this order) | | | | | | | | |
| 01961, 01967, and/or 01968 | AA and QS or QZ and QS or QX and QS | | | | | | | | |

Definitions

| | |
|-------------------------|--|
| Allowable Amount | 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. |
|-------------------------|--|

| | |
|----------------------------------|---|
| 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 | <p>Per the ASA Monitored Anesthesia Care includes all aspects of anesthesia care – a preprocedure visit, intraprocedure care and postprocedure anesthesia management. During Monitored Anesthesia Care, the anesthesiologist provides or medically directs a number of specific services, including but not limited to:</p> <ul style="list-style-type: none"> • 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. <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> |

| | |
|--|--|
| | 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 | <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 <i>Crosswalk</i>® and report an ASA 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 the subsequent management of Intravenous (IV) Patient-Controlled Analgesia (PCA) be reported?</p> <p>A: Any subsequent IV PCA management services should not be reported separately. The hospital nursing staff is responsible for the ongoing IV PCA monitoring that is considered included in the surgeon's global fee, and any subsequent IV PCA management by a physician is considered to be included in the postoperative evaluation and management visits.</p> |
| 5 | <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 Community Plan, CRNA services must be reported under the CRNA's name.</p> |

| | |
|----|---|
| 6 | <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 or GC.</p> |
| 7 | <p>Q: CPT code 01967 (Neuraxial labor analgesia/anesthesia for planned vaginal delivery) is performed by an anesthesiologist 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 anesthesiologist 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, the appropriate modifier 59, 76, 77, 78, 79, or XE to indicate the anesthesia management service was separate and subsequent to the original anesthesia management service reported with CPT code 01967.</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 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 management service with modifier QX and the supervising physician should report the same anesthesia management service with modifier QK, QY or AD.</p> |
| 9 | <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: Claims should be submitted as follows:</p> <p>Electronic Claims: According to The Health Insurance Portability and Accountability Act of 1996 (HIPAA) guidelines, electronic claims submitted via the 837 Professional transaction set, should have anesthesia minutes reported in loop 2400 SV104 with an MJ qualifier in loop 2400 SV103 per the 837 Implementation Guide.</p> <p>Paper Claims with CMS Paper Format 02-12: Per UnitedHealthcare Community Plan guidelines, for claims submitted in paper format on a 1500 Health Insurance Claim Form (a/k/a CMS-1500) 02-12, Anesthesia Time (duration in minutes with start and end times) should be entered in the shaded areas of fields 24 A-K and the total minutes in field 24G for each applicable service line. The qualifier 7 (Anesthesia information) is to be used when reporting Anesthesia Time services. To enter supplemental information, begin at field 24A:</p> <ul style="list-style-type: none"> • Enter the qualifier 7 and then the information • Do not enter a space between the qualifier and the number/code/information • Do not enter hyphens or spaces within the number/code • More than one supplemental item can be reported in the shaded lines of Item Number 24 • Enter the qualifier and number/code/information at 24A. At the first item, enter three blank spaces and then the next qualifier and number/code/information. • A sample entry in the shaded area of fields 24 A-K: 7 Begin 1245 End 1415 Time 90 minutes <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> |
| 10 | <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> |
| 11 | <p>Q: The policy states to submit supporting documentation. What is the best approach to take?</p> <p>A: Submit a paper claim using the CMS form accompanied by the requested documentation.</p> |

| | |
|-----------|---|
| 12 | <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> |
| 13 | <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> |

Attachments

| | |
|--|---|
| <u>LA Anesthesia Codes</u> | Identifies codes that are considered anesthesia (base + time) services. |
| <u>LA Evaluation and Management Codes Bundled into Anesthesia</u> | Identifies Evaluation and Management codes considered to be included in the Base Unit Value for the anesthesia service. |
| <u>LA Procedural or Pain Management Codes Bundled into Anesthesia</u> | Identifies codes included in the Base Unit Value for the anesthesia service. |
| <u>LA Procedural or Pain Management Bundled Codes Allowed with Modifiers</u> | 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. |
| <u>LA Anesthesia Services Bundled into HCPCS Procedural Codes</u> | Identifies medical/surgical procedures reported as HCPCS codes and their direct or alternate crosswalk anesthesia codes |

Resources

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

American Society of Anesthesiologists, Relative Value Guide®

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

Centers for Medicare and Medicaid Services, National Correct Coding Initiative (NCCI) publications

Centers for Medicare and Medicaid Services, Physician Fee Schedule (PFS) Relative Value Files

National Uniform Claim Committee (NUCC)

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

Federal Register

Vol. 74, No. 226

Wednesday, November 25, 2009

Page 61867

Centers for Medicare and Medicaid Services, Medicare Program

Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B (for CY 2010)**Section 139: Improvements for Medicare Anesthesia Teaching Programs**http://www.access.gpo.gov/su_docs/fedreg/frcont09.html**History**

| | |
|------------------|---|
| 1/14/2024 | Policy Version Change Modifier Section: Updated information on Modifier 23 Header: Updated Branding Archive History prior to 1/14/2022 |
| 3/25/2006 | Policy Implemented by UnitedHealthcare Community & State |