UnitedHealthcare®

Reimbursement Policy

Anesthesia Services

Policy Number	ANES08272009RP	**Approved By**	UnitedHealthcare Medicare Reimbursement Policy Committee	**Current Approval Date**	08/27/2014

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

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

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare reimbursement policies use Current Procedural Terminology (CPT®*), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms (CMS 1450). Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general resource regarding UnitedHealthcare'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, and/or the enrollee's benefit coverage documents. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare 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 Health Insurance Claim Form CMS-1500 or its electronic equivalent or its successor form, and services reported using facility claim form CMS-1450 or its electronic equivalent or its successor form. This policy applies to all products, all network and non-network physicians, and other health care professionals.

The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This policy does not take

precedence over CCI edits. Please refer to the CCI for correct coding guidelines and specific applicable code combinations prior to billing UnitedHealthcare. It is not enough to link the procedure code to a correct, payable ICD-9-CM diagnosis code. The diagnosis must be present for the procedure to be paid. Compliance with the provisions in this policy is subject to monitoring by pre-payment review and/or post-payment data analysis and subsequent medical review. The effective date of changes/additions/deletions to this policy is the committee meeting date unless otherwise indicated.

Summary

Overview

UnitedHealthcare Medicare Advantage's reimbursement policy for anesthesia services is developed in part using the American Society of Anesthesiologists (ASA) Relative Value Guide (RVG®), the ASA CROSSWALK®, and Centers for Medicare and Medicaid Services (CMS) methodology. Current Procedural Terminology (CPT®) codes and modifiers and 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 or pain management services.

Reimbursement Guidelines

Anesthesia services must be submitted with a CPT anesthesia code in the range 00100-01999, excluding 01953 and 01996, and are reimbursed as time-based using the Standard Anesthesia Formula. 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.

Reimbursement Formula

Base Values:

Each CPT anesthesia code is assigned a Base Value by the ASA, and UnitedHealthcare Medicare and Retirement uses these values for determining reimbursement. The Base Value of each code is comprised of units referred to as the Base Unit Value.

Time Reporting:

Consistent with CMS guidelines, UnitedHealthcare Medicare and Retirement 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.

Reimbursement Formulas:

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

Standard Anesthesia Formula without Modifier AD* = ([Base Unit Value + Time Units + Modifying Units] x Conversion Factor) x Modifier Percentage.

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

**For additional information, refer to Modifiers.*

Qualifying Circumstances

Qualifying circumstances codes identify conditions that significantly affect the nature of the anesthetic service provided. Consistent with CMS guidelines, UnitedHealthcare Medicare and Retirement does not allow additional base units for qualifying circumstance codes. The qualifying circumstances codes are 99100, 99116, 99135

and 99140.

Multiple Anesthesia Services

According to the ASA, when multiple surgical procedures are performed during a single anesthesia administration, only the single anesthesia code with the highest Base Unit Value is reported. The time reported is the combined total for all procedures performed on the same patient on the same date of service by the same or different physician or other qualified health care professional.

Code 01953 is an add-on-code and is used in conjunction with code 01952 (5 base units). Anesthesia add-on codes are priced differently. Only the base unit of the add-on code should be allowed. The anesthesia time should be reported with the primary anesthesia code.

Duplicate Anesthesia Services

When duplicate (same) anesthesia codes are reported by the same or different physician or other qualified health care professional for the same patient on the same date of service, UnitedHealthcare Medicare and Retirement will only reimburse the first submission of that code. Specific reimbursement percentages are based on the anesthesia modifier(s) reported.

Anesthesia and Procedural Bundled Services

UnitedHealthcare Medicare and Retirement uses the CMS National Correct Coding Initiative (NCCI) Policy Manual, CMS NCCI edits and the CMS National Physician Fee Schedule when considering procedural or pain management services that are an integral part of anesthesia services, and anesthesia services that are an integral part of procedural or pain management services, which are not separately reimbursable when performed by the Same Individual Physician or Other Qualified Health Care Professional on the same date of service.

The CMS NCCI Policy manual states that "many standard preparation, monitoring, and procedural services are considered integral to the anesthesia service. Although some of the services would never be appropriately reported on the same date of service as anesthesia management, many of these services could be provided at a separate patient encounter unrelated to the anesthesia management on the same date of service." According to the NCCI Policy Manual, Chapter 1, CMS does not allow separate payment for anesthesia services performed by the physician who also furnishes the medical or surgical procedure, excluding Moderate Sedation. In these situations, the allowance for the anesthesia service is included in the payment for the medical or surgical procedure. In addition, AMA states “if a physician personally performs the regional or general anesthesia for a surgical procedure that he or she also performs, modifier 47 would be appended to the surgical code, and no codes from the anesthesia section would be used.”

UnitedHealthcare will not separately reimburse an anesthesia service when reported with a medical or surgical procedure (where the anesthesia service is the direct or alternate crosswalk code for the medical or surgical procedure) submitted by the Same Individual Physician or Other Qualified Health Care Professional for the same patient on the same date of service.

Preoperative/Postoperative Visits

Consistent with CMS, UnitedHealthcare Medicare and Retirement will not separately reimburse an E/M service (excluding critical care CPT codes 99291-99292) when reported by the Same Specialty Physician or Other Qualified Health Care Professional on the same date of service as an anesthesia service.

Critical care CPT codes 99291-99292 are not considered included in an anesthesia service and will be separately reimbursed.

The Same Specialty Physician or Other Qualified Health Care Professional is defined as physicians and/or other qualified health care professionals of the same group and same specialty reporting the same Federal Tax Identification number.

Daily Hospital Management

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

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

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Moderate Sedation Overview

*Current Procedural Terminology (*CPT®) defines Moderate (conscious) Sedation as a drug induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. In addition, 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.

Moderate Sedation services reported by the Same Physician or Other Qualified Health Care Professional reporting the diagnostic or therapeutic procedure, are separately reimbursable services when submitted under CPT codes 99143-99145 except when reported for the procedures noted below. Moderate Sedation services performed by a second physician or other qualified health care professional are separately reimbursable services when submitted under CPT codes 99148-99150 in a facility place of service.

UnitedHealthcare's reimbursement policy for Moderate Sedation services is based on methodologies used and recognized by the Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) edits and Policy Manual, and CPT codebook guidelines.

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

Attending Physician (99143-99145)

UnitedHealthcare will allow separate reimbursement for Moderate Sedation services reported using CPT codes 99143-99145 when provided by the Same Physician or Other Qualified Health Care Professional reporting the diagnostic or therapeutic procedure except for:

1. Procedures listed in Appendix G of the CPT book
2. Anesthesia procedures (CPT codes 00100-01999)
3. CPT and HCPCS codes that are part of CMS NCCI edits

The procedures above include Moderate Sedation as an inherent part of providing the service. Refer to the list in Appendix G of the CPT book for a comprehensive listing of the non-anesthesia procedures that include Moderate Sedation and for which CPT codes 99143-99145 will not be considered separately.

Second Physician (99148-99150)

Moderate Sedation services performed by a physician or other qualified health care professional other than the health care professional performing the diagnostic or therapeutic procedure that the sedation supports, in a facility place of service (e.g., hospital, ambulatory surgery center), are eligible for reimbursement and should be reported using CPT codes 99148 - 99150 along with the appropriate facility place of service code.

A second physician or other qualified health care professional should not report CPT codes 99148-99150 for Moderate Sedation provided in a place of service other than a facility. Moderate Sedation services performed by a second physician or other qualified health care professional in a place of service other than a facility will not be separately reimbursed.

Refer to the following types of facilities where services can be separately reimbursed.

Drug Reimbursement

The cost of the drug used in Moderate Sedation, if supplied by the physician in a location other than inpatient/outpatient hospital, emergency room or ambulatory surgical center, is reimbursable at the appropriate fee schedule or contracted rate.

CPT / HCPCS Codes

Code	Description
99143	Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patients level of consciousness and physiological status; younger than 5 years of age, first 30 minutes intra-service time

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99144	Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patients level of consciousness and physiological status; age 5 years or older, first 30 minutes intra-service time
99145	Moderate sedation services (other than those services described by codes 00100-01999) provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patients level of consciousness and physiological status; each additional 15 minutes intra-service time (List separately in addition to code for primary service)
99148	Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician or other qualified health care professional other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; younger than 5 years of age, first 30 minutes intra-service time
99149	Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician or other qualified health care professional other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; age 5 years or older, first 30 minutes intra-service time
99150	Moderate sedation services (other than those services described by codes 00100-01999), provided by a physician or other qualified health care professional other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intra-service time (List separately in addition to code for primary service)
99100	Anesthesia for patient of extreme age, younger than 1 year and older than 70 (List separately in addition to code for primary anesthesia procedure). Additional base units are not allowed. *(Per the ASA RVG® an additional unit for 99100 is not allowed with anesthesia codes 00326, 00561, 00834 and 00836)*
99116	Anesthesia complicated by utilization of total body hypothermia (List separately in addition to code for primary anesthesia procedure). Additional base units are not allowed. *(Per the ASA RVG® additional units for 99116 are not allowed with anesthesia codes 00561, 00562, 00563, 00566, and 00567)*
99135	Anesthesia complicated by utilization of controlled hypotension (List separately in addition to code for primary anesthesia procedure). Additional base units are not allowed. *(Per the ASA RVG® additional units for 99135 are not allowed with anesthesia codes 00561, 00562, 00563, 00566, and 00567)*
99140	Anesthesia complicated by emergency conditions (specify) (List separately in addition to code for primary anesthesia procedure) Additional base units are not allowed. *(An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part.)*

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

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

Questions and Answers	
Q:	A second physician has rendered Moderate Sedation in a non-facility setting. Will his/her services be separately reimbursed?
A:	In a non-facility setting the second physician's fee is included in the fee for the global procedure.

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References Included (but not limited to):

CMS Claims Processing Manual

Chapter 12; § 50 Payment for Anesthesiology Services

CMS Transmittals

Transmittal B-03-017, Change Request 2539, Dated 02/28/2003 (Add-On-Codes for Anesthesia)

UnitedHealthcare Medicare & Retirement Reimbursement Policies

Medicare Physician Fee Schedule Status Indicator Policy

MLN Matters

Article MM5618, Anesthesia Services Furnished by the Same Physician Providing the Medical and Surgical Service

Others

NCCI Anesthesia Services

NCCI Manual Anesthesia

History

Date	Revisions
08/27/2014	New Policy