Anesthesia - Medicare

Policy Number: UM14P0008A6

Effective Date: August 1, 2014

Last Update: September 29, 2021

PAYMENT POLICY HISTORY

DATE	SUMMARY OF CHANGE
September 29, 2021	Annual policy review completed. No technical changes were made to the policy.
October 6, 2020	Annual policy review completed. No technical changes were made to the policy. Information was moved to the new UCare format, and as a result some information was reformatted.
April 2, 2019	Annual policy review. Other than updating the UCare logo no changes were made to the policy.
August 2018	Annual policy review. Added information and link regarding UCare fee schedule updates. Information regarding conscious sedation was removed from the policy.
December 2016	Annual policy review, no changes made.
December 2015	Annual policy review, no changes made.
August 1, 2014	The Anesthesia (Medicare) policy is published by UCare.

AUDIENCE

Indicates whether this policy will be published only internally of the policy will be published internally and externally.	
Internal	√
External	√

APPLICABLE PRODUCTS

This policy applies to the UCare products checked below:

UCare Connect +Medicare (When MHCP is the primary payer)	√
UCare Minnesota Senior Health Options (MSHO) (When MHCP is the primary payer)	√
UCare Medicare Plans	√
UCare EssentiaCare	√

UCare Medicare M-Health Fairview & North Memorial	√

TABLE OF CONTENTS

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PAYMENT POLICY INSTRUCTIONS

A payment policy assists in determining provider reimbursement for specific covered services. To receive payment, the provider must be in a contractual relationship with UCare and provide services to a member enrolled in one of UCare's products. This payment policy is intended to provide a foundation for system configuration, work instructions, call scripts, and provider communications. A payment policy describes the rules for payment, which include applicable fee schedules, additional payment rules by regulatory bodies, and contractual terms. This policy is a general guideline and may be superseded by specific provider contract language.

PAYMENT POLICY OVERVIEW

This policy outlines the appropriate use of modifiers, and the billing and payment guidelines associated with general anesthesia and monitored anesthesia care (MAC)

POLICY DEFINITIONS

TERM	NARRATIVE DESCRIPTION
Anesthesia Assistant (AA)	An AA is a maters level educated individual who can work collaboratively under the direction of an anesthesiologist. Anesthesiologist assistants obtain pre-anesthetic health history, perform preoperative physical exams, establish non-invasive and invasive monitors, administer medications, evaluate, and treat life-threatening situations, and execute general and regional anesthetic techniques, as delegated by the anesthesiologist.
Base Units or Base Value	Means the number of units assigned to the ASA code (0100 – 01999).
Certified Registered Nurse Anesthetist (CRNA)	Certified Registered Nurse Anesthetist (CRNA) is an advanced practice registered nurse (APRN) who has acquired graduate-level education and board certification in anesthesia.
General Anesthesia	Loss of ability to perceive pain, associated with the loss of consciousness, produced by intravenous infusion of drugs or inhalation of anesthetic agents.
Medically Directed	Concurrency is defined regarding the maximum number of procedures that the physician is medically directing within the context of a single procedure and whether these other procedures overlap each other. Medical direction occurs if the physician medically directs qualified

TERM	NARRATIVE DESCRIPTION
	individuals in two, three, or four concurrent cases, and the physician performs the following activities: • Pre-anesthetic examination and evaluation • Prescribes the anesthesia plan • Personally participates in the most demanding procedures in the anesthesia plan, including, if applicable, induction and emergence • Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist • Monitors the course of anesthesia administration at frequent intervals • Remains physically present and available for immediate diagnosis and treatment of emergencies • Provides indicated post-anesthesia care The medical record must reflect that the physician performed services as indicated above. It should be noted that if anesthesiologists are in a group practice, one physician may provide the pre- and/ post-anesthesia exam and evaluation while another fulfills the other criteria. The medical record must reflect that services were performed by physicians and identify the physicians who furnished them.
Medically Supervised	Based on review of Medicare documents medically supervised care occurs when the anesthesiologist is involved in supervising more than four procedures concurrently or is performing other services for a significant period while directing concurrent procedures.
Monitored Anesthesia Care (MAC)	Intra-operative monitoring by an anesthesiologist or other qualified provider under the direction of the anesthesiologist, of the patient's vital physiological signs in anticipation of the need for admission of general anesthesia or the development of adverse physiological patient reaction to the surgical procedure. MAC is eligible for payment when performed by an eligible provider (see above), and all the following criteria is met: • MAC is requested by the attending physician or operating surgeon; • There is performance of a pre-anesthetic examination and evaluation; • There is a prescriptive anesthesia plan outlining the anesthesia care required; • Administration of necessary oral and parenteral medication takes place, and; • There is continuous physical presence of the anesthesiologist or in the case of medical direction, a qualified anesthetist.
Personally Performed	A simple definition is that the physician personally performed all pre-operative, intra-operative, and postoperative anesthesia care.

TERM	NARRATIVE DESCRIPTION
	Medicare states the anesthesiologist may bill for personally performed services when he or she: • Personally performed the entire anesthesia service alone • Are Involved with one anesthesia case with a resident, the physician is a teaching physician, and the services are performed on or after January 1, 1996 • Are involved in the training of physician residents in a single anesthesia care, two concurrent anesthesia cases involving residents or a single anesthesia case involving a resident that is concurrent to another case paid under the medical direction rules. The physician meets the teaching criteria in Section 100.14 and the service is furnished on or after January 1, 2010 • Are continuously involved in a single case involving a student nurse anesthetist.

ENROLLEE ELIGIBILITY CRITERIA

THIS SECTION OF THE POLICY PROVIDES INFORMATION THAT IS SPECIFIC TO THE UCARE MEMBER, INCLUDING INFORMATION ABOUT THE CRITERIA THE MEMBER MUST MEET IN ORDER FOR THE SERVICE(S) IN THE POLICY TO BE ELIGIBLE FOR PAYMENT

The member must be actively enrolled in an UCare product.

ELIGIBLE PROVIDERS OR FACILITIES

OUTLINED BELOW IS THE SPECIFIC CRITERIA A PROVIDER MUST MEET IN ORDER FOR THE SERVICE(S) IN THIS POLICY TO BE ELIGIBLE FOR PAYMENT. THE SERVICE(S) IN THE POLICY TO BE ELIGIBLE FOR PAYMENT

Provider

The following providers are eligible to furnish and bill for the Anesthesia services:

- Anesthesiologist
- CRNA
- Anesthesia Assistant (AA)

NOTE: Medicare's and MHCP's list of eligible providers are ***not*** the same.

Facility

Not applicable; the policy covers billing of professional services.

Other and/or Additional Information

Not applicable.

EXLUDED PROVIDER TYPES

OUTLINED BELOW IS INFORMATION REGARDING PROVIDERS WHO ARE NOT ELIGIBLE TO FURNISH THE SERVICE(S) LISTED IN THIS POLICY.

Not applicable.

MODIFIERS, CPT, HCPCS, AND REVENUE CODES

General Information

The Current Procedural Terminology (CPT®) HCPCS, and Revenue codes listed in this policy are for reference purposes only. Including information in this policy does not imply that the service described by a code is a covered or non-covered health service. The inclusion of a code does not imply any right to reimbursement or guarantee of claim payment.

Modifiers

The modifiers listed below are not intended to be a comprehensive list of all modifiers. Instead, the modifiers that are listed are those that must be appended to the CPT® / HCPCS codes listed below. Based on the service(s) provided, and the circumstances surrounding those services it may, based on correct coding, be appropriate to append an additional modifier(s) to the CPT® / HCPCS code.

When a service requires multiple modifiers, the modifiers must be submitted in the order listed below. If it is necessary to add additional modifiers they should be added after the modifiers listed below.

Anesthesia Modifiers

Modifiers appended to anesthesia claims have a significant impact on payment. Detailed information regarding anesthesia modifiers, their use and impact on payment is outlined in the Billing Guidelines / Direction for Use section of this Policy.

MODIFIER(S)	NARRATIVE DESCRIPTION
AA	Anesthesia Services performed personally by the anesthesiologist

MODIFIER(S)	NARRATIVE DESCRIPTION
AD	Medical Supervision by a physician; more than 4 concurrent anesthesia procedures
G8	Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedures
G9	Monitored anesthesia care for patient who has a history of severe cardio-pulmonary condition
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals
QS	Monitored anesthesia care service (The –QS modifier can be used by a physician or a qualified non-physician anesthetist and is for informational purposes. Providers must report actual anesthesia time and one of the payment modifiers when submitting a claim).
QY	Medical direction of one qualified non-physician anesthetist by an anesthesiologist
GC	These services have been performed by a resident under the direction of a teaching physician. (The GC modifier is reported by the teaching physician to indicate he/she rendered the service in compliance with the teaching physician requirements in §100 of this chapter. One of the payment modifiers must be used in conjunction with the GC modifier).

Revenue Codes

Not applicable.

CPT and/or HCPCS Code(s)

General Information

For general anesthesia and monitored anesthesia care (MAC) the code-set established by the American Academy of Anesthesiologists (ASA) is used to bill for anesthesia care. Services should be billed using the most current and appropriate ASA code. Additional anesthesia related codes are outlined below:

CPT AND/OR HCPCS CODE(S)	NARRATIVE DESCRIPTION
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).
99116	Anesthesia complicated by utilization of total body hypothermia (List separately in addition to code for primary anesthesia procedure).
99135	Anesthesia complicated by utilization of controlled hypotension (List separately in addition to code for primary anesthesia procedure).

CPT AND/OR HCPCS CODE(S)	NARRATIVE DESCRIPTION
99140	Anesthesia complicated by emergency conditions (specify) (List separately in addition to code for primary anesthesia procedure).
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 patient's level of consciousness and physiological status; younger than 5 years of age, first 30 minutes intra-service time.
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 patient's 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 patient's 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).

PAYMENT INFORMATION

General Anesthesia

Code-Set

UCare uses anesthesia codes and base values adopted from the list values established by the American Society of Anesthesiologists (ASA).

Payment Guidelines

Anesthesia administration includes the following services:

- Preoperative and postoperative visits
- Anesthesia care during the procedure
- Administration of fluids and blood
- Usual monitoring (e.g., ECG, temperature, blood pressure, oximetry, capnography, mass spectrometry) as defined by ASA (American Society of Anesthesiologists and/or CPT guidelines.

General Anesthesia is personally performed by an anesthesiologist or CRNA/AA (medically directed by an anesthesiologist, or medically supervised by an anesthesiologist).

Outlined below is general information related to the reimbursement formulas used for UCare's Medicare Products or Dual eligible State Public Programs when Medicare is responsible for the primary payment:

Reimbursement Formula

REIMBURSEMENT FORMULA	PAYMENT INFORMATION
Personally, Performed and Medically Directed Formula (ASA Base Units) + (Total Time / 15rounded up to a whole unit x Current Conversion Factor) ***Medically Supervised*** Allow three (3) base units, and one (1) additional base unit when it is demonstrated that the physician was present at the induction x Current Conversion Factor	***Personally Performed*** – 100% of the allowed amount ***Medically Directed*** – 50% of the allowed amount ***Medically Supervised*** – Refer to the modifier payment grid listed below.

Monitored Anesthesia Care

General Information

Medicare requires the anesthesiologist, CRNA, or AA to continuously provide the services outlined below:

- Administration of medication
- IV access
- Maintenance of sedation
- Monitoring of oxygen saturation/heart rate/blood pressure
- Patient assessment
- Recovery (not included in intra-service time)
- Based on CPT guidelines CPT codes 99143 – 99145 will not be separately reimbursed with any procedures listed in the CPT Book, Appendix "G" (Summary of CPT Codes that Include Moderate Sedation.
- Based on CPT guidelines do not report anesthesia services for diagnostic or therapeutic injections and nerve blocks or pulse oximetry.
- On the rare occasion when it is medically necessary for the services of both a physician and a CRNA to be involved in a single case documentation must be submitted by both the physician and the CRNA. In this situation, the physician will bill using the –AA modifier, and the CRNA will bill using the –QZ modifier.

Modifier Payment Grid and Additional Payment Information

The allowed amount is determined based on the anesthesia procedure that has the highest ASA base unit value. Information regarding payment is outlined below:

ANESTHESIA OVERSIGHT	MODIFIER	MODIFIER NARRATIVE	PROVIDER TYPE	ADDITIONAL MEDICARE INFORMATION
Personally Performed	AA	Anesthesia Services personally performed by the anesthesiologist	Anesthesiologist	Reimbursed at 100% of the Medicare allowed amount
	QZ	CRNA service without medical direction by a physician	CRNA / AA	Reimbursed at 100% of the Medicare allowed amount
	AD	Medical Supervision by a physician, more	Anesthesiologist	Allow three (3) base units, and one (1) additional base

ANESTHESIA OVERSIGHT	MODIFIER	MODIFIER NARRATIVE	PROVIDER TYPE	ADDITIONAL MEDICARE INFORMATION
Medically Directed / Supervised		than four (4) concurrent anesthesia procedures		unit when it is demonstrated that the physician was present at the induction
	QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals	Anesthesiologist	Reimbursed at 50% of the Medicare allowed amount
	QY	Medical direction of one CRNA / AA by an anesthesiologist	Anesthesiologist	Reimbursed at 50% of the Medicare allowed amount
	QX	CRNA service with medical direction by a physician	CRNA / AA	Reimbursed at 50% of the Medicare allowed amount
Resident - Teaching Facility	GC	Services performed by a Resident under the direction of a teaching physician	Anesthesiologist	The GC modifier is reported by the *teaching physician* to indicate they rendered the service in compliance with Chapter 12, Section 100.1.2 of Medicare's Claims Processing Manual. • If the teaching anesthesiologist is involved in a single case with an anesthesiology resident payment is the same as if the physician performed the service alone. • If the teaching anesthesiologist is medically directing 2 – 4 concurrent cases, any of which involved residents, payment is

ANESTHESIA OVERSIGHT	MODIFIER	MODIFIER NARRATIVE	PROVIDER TYPE	ADDITIONAL MEDICARE INFORMATION
				based on 50% of the anesthesia fee schedule (standard for payment method). One of the payment modifiers listed above must be used in conjunction with the –GC modifier.
Monitored Anesthesia Care (MAC)	G8	Monitored anesthesia care (MAC) for deep complex, complicated or markedly invasive surgical procedures	Anesthesiologist CRNA / AA	• Informational modifier to indicate MAC services were provided • The personally performed or the appropriate medical direction modifier must be submitted with this modifier. • Submit actual time on the claim • Payment guidelines – same as general anesthesia
	G9	Monitored anesthesia for a patient who has a history of severe cardio-pulmonary condition	Anesthesiologist, CRNA /AA	See Above
	QS	Monitored Anesthesia Care	Anesthesiologist, CRNA /AA	See Above
Physical Status Modifiers	P1	A normal health patient	NA	• Informational only; does not impact payment
	P2	A patient with mild systemic disease	NA	• Informational only; does not impact payment
	P3	A patient with sever systemic disease	NA	• Informational only; does not impact payment

ANESTHESIA OVERSIGHT	MODIFIER	MODIFIER NARRATIVE	PROVIDER TYPE	ADDITIONAL MEDICARE INFORMATION
	P4	A patient with sever systemic disease that is a constant threat to life	NA	• Informational only; does not impact payment
	P5	A moribund patient who is not expected to survive without the operation	NA	• Informational only; does not impact payment
	P6	A declared brain-dead patient whose organs are being removed for donor purposes	NA	• Informational only; does not impact payment

BILLING REQUIREMENTS AND DIRECTIONS

When submitting claims follow the guidelines outlined below:

- Claims should be submitted using the 837-P format or the electronic equivalent;
- Do not submit anesthesia base units on the claim. They will be included in the calculation of the allowed amount;
- For anesthesia time:
    - Submit the exact number of minutes from the preparation of the patient for induction to the time the anesthesiologist or CRNA are no longer in personal attendance or continue to be required;
    - UCare will translate the number of anesthesia minutes submitted by the provider to units of service;
    - Fifteen (15) minutes of time equals one unit of service; and
    - Units will be calculated to one decimal point. (Example: 62 minutes / 15 = 4.1 units of service).

PRIOR AUTHORIZATI0N, NOTIFICATION, AND THRESHOLD INFORMATION

Prior Authorization and Notification Requirements

UCare does update its' authorization, notification, and threshold requirements from time-to-time. The most current prior authorization requirements can be found here.

Threshold Information

Not applicable.

RELATED PAYMENT POLICY INFORMATION

OUTLINED BELOW ARE OTHER POLICIES THAT MAY RELATE TO THIS POLICY AND/OR MAY HAVE AN IMPACT ON THIS POLICY.

POLICY NUMBER	POLICY TITLE
SC14P0005A6	Anesthesia - MHCP

UCare payment policies are updated from time to time. The most current UCare payment policies can be found here.

SOURCE DOCUMENTS AND REGULATORY REFENCES

LISTED BELOW ARE LINKS TO CMS, MHCP, AND STATUTORY AND REGULATORY REFERENCES USED TO CREATE THIS POLICY

NGS

NGS Medicare, Anesthesia Billing Guide: Payment and Reimbursement, December 2018

NGS Medicare, Anesthesia Billing Guide, Index, December 2018

CMS

Anesthesiologist Center

IOM-04 Medicare Claims Processing Manual, Chapter 12 Physicians/Nonphysician Practitioners, Section 50

MM6706, MIPPA Section 139 Teaching Anesthesiologists

DISCLAIMER

"Payment Policies assist in administering payment for UCare benefits under UCare's health benefit plans. Payment Policies are intended to serve only as a general reference resource regarding UCare's administration of health benefits and are not intended to address all issues related to payment for health care services provided to UCare members. When submitting claims, all providers must first identify member eligibility, federal and state legislation, or regulatory guidance regarding claims submission, UCare provider participation agreement contract terms, and the member-specific Evidence of Coverage (EOC) or other benefit document. In the event of a conflict, these sources supersede the Payment Policies. Payment Policies are provided for informational purposes and do not constitute coding or compliance advice. Providers are responsible for submission of accurate and compliant claims. In addition to Payment Policies, UCare also uses tools developed by third parties, such as the Current Procedural Terminology (CPT®*), InterQual guidelines, Centers for Medicare and Medicaid Services (CMS), the Minnesota Department of Human Services (DHS), or other coding guidelines, to assist in administering health benefits. References to CPT® or other sources in UCare Payment Policies are for definitional purposes only and do not imply any right to payment. Other UCare Policies and Coverage Determination Guidelines may also apply. UCare reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary and to administer payments in a manner other than as described by UCare Payment Policies when necessitated by operational considerations."