ANESTHESIA - MHCP

Policy Number: SC14P0005A2  Effective Date: August 19, 2014

Last Reviewed: January 1, 2016

**PAYMENT POLICY HISTORY**

<table>
<thead>
<tr>
<th>DATE</th>
<th>ACTION / DESCRIPTION</th>
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| January 1, 2016    | 1. Grammatical changes were made to improve the clarity of the document.  
2. The formula used to calculate the allowed amount was added to the modifier grid.  
3. Based on updates from MHCP when appropriate four units of service will be allowed when calculating the allowed amount for services appended with the –AD (Medical Supervision by a physician, more than four (4) concurrent anesthesia procedures) modifier. |

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“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. In particular, 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.”

*CPT® is a registered trademark of the American Medical Association
**PRODUCT SUMMARY**

This Policy applies to UCare’s MHCP product and any UCare product where MHCP is the primary payer.

**PROVIDER SUMMARY**

This Policy applies to professional claims.

**POLICY STATEMENT**

This Policy covers the billing, appropriate use of modifiers and payment guidelines associated with general anesthesia, monitored anesthesia care (MAC) (aka moderate sedation), and Conscious Sedation.

**PATIENT ELIGIBILITY CRITERIA**

UCare Enrollee eligible for coverage

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### DEFINITIONS

<table>
<thead>
<tr>
<th>TERM</th>
<th>NARRATIVE DESCRIPTION</th>
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<tbody>
<tr>
<td>Personally Performed</td>
<td>The physician personally performed all of the pre-operative, intra-operative, and postoperative anesthesia care.</td>
</tr>
</tbody>
</table>

UCare and MHCP follows Medicare guidelines regarding the definition of personally performed services stating that 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
- 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.
<table>
<thead>
<tr>
<th>TERM</th>
<th>NARRATIVE DESCRIPTION</th>
</tr>
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</table>
| Medically Directed   | Concurrency is defined with regard to 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 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. |
| 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.                                                                 |
| Monitored Anesthesia Care | 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 coverage when performed by an eligible provider (see above), and all of 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
- There is continuous physical presence of the anesthesiologist or in the case of medical direction, a qualified anesthetist

Conscious Sedation

A minimally depressed level of consciousness induced by the administration of pharmacologic agents in which a patient retains the ability to independently and continuously maintain an open airway and a regular breathing pattern, and to respond appropriately and rationally to physical stimulation and verbal commands. Conscious sedation may be induced by parenteral or oral medications or combination thereof.

**POLICY AND BILLING INFORMATION**

**GENERAL ANESTHESIA**

**Code Set**

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

**General Information**

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, medically directed by an anesthesiologist, or medically supervised by an anesthesiologist. Anesthesia Assistants are not recognized as an eligible provider for MHCP products.

**REIMBURSEMENT FORMULAS**

Outlined below is general information related to the reimbursement formulas used by UCare for MHCP claims.

**Personally Performed**

(ASA Base Units) + (Total Time / 15 rounded to one decimal point) x Current Conversion Factor

**Medically Directed**

(ASA Base Units) + (Total Time / 15 rounded to one decimal point) x Current Conversion Factor x 0.632

**Medically Supervised**

Not to four (4) base units x Current Conversion Factor

**MODERATE (aka) CONSCIOUS SEDATION**

**General Information**

Both Medicare and Medicaid require the anesthesiologist, or CRNA, 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 (Conscious) Sedation).
- Based on CPT guidelines do not report with anesthesia for diagnostic or therapeutic injections and nerve blocks or pulse oximetry.
- Medicare states that in the unusual event when a second physician other than the provider performing the diagnostic or therapeutic services provides conscious sedation in the facility setting for services listed in Appendix “G” of CPT, the second physician can bill conscious sedation services.
When services are performed in a non-facility setting, conscious sedation codes should not be reported.

**GENERAL AND MONITORED ANESTHESIA CARE (MAC)**

<table>
<thead>
<tr>
<th>GENERAL INFORMATION</th>
<th>MHCP</th>
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<tbody>
<tr>
<td>Code Set</td>
<td>ASA (American Academy of Anesthesiologists)</td>
</tr>
<tr>
<td>Payment</td>
<td>The allowed amount is determined based on the anesthesia procedure that has the highest base unit value</td>
</tr>
<tr>
<td>Base Units</td>
<td>Do not submit base units on the claim, they will be included in the calculation of the allowed amount.</td>
</tr>
</tbody>
</table>
| 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.  
- 15 minutes of time equal one unit of service.  
- Units will be calculated to one decimal point. (Example: 62 minutes / 15 = 4.1 units of service) |
| Additional Payment for Physical Status Modifiers | No |
| Qualifying Circumstances Codes (99100 – 99140) | CPT code 99100 (Extreme age younger than 1 year or older than 70) is the only code that will be allowed separately. This code should be billed on a separate line, and no anesthesia modifiers should be appended to the CPT code. |
| Placement of central venous lines, arterial catheters, Swan-Ganz catheters | Separately billable |
| Surgical Procedure is cancelled | If an anesthetic is not administered an evaluation and management service should be billed. |
ANESTHESIA MODIFIERS

Outlined below is specific information regarding the use of modifiers, eligible providers and the formula that will be used to calculate the allowed amount for anesthesia services:

<table>
<thead>
<tr>
<th>ANESTHESIA OVERSIGHT</th>
<th>MODIFIER</th>
<th>MODIFIER NARRATIVE</th>
<th>PROVIDER TYPE</th>
<th>ADDITIONAL UCare INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personally Performed</td>
<td>AA</td>
<td>Anesthesia Services personally performed by the anesthesiologist</td>
<td>Anesthesiologist</td>
<td>(Base Units) + (Time Units) / 15 x Conversion Factor</td>
</tr>
<tr>
<td></td>
<td>QZ</td>
<td>CRNA service without medical direction by a physician</td>
<td>CRNA</td>
<td>Base Units) + (Time Units) / 15 x Conversion Factor</td>
</tr>
<tr>
<td>Medically Directed / Supervised</td>
<td>AD</td>
<td>Medical Supervision by a physician, more than four (4) concurrent anesthesia procedures</td>
<td>Anesthesiologist</td>
<td>Four (4) Base Units x Conversion Factor</td>
</tr>
<tr>
<td></td>
<td>QK</td>
<td>Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals</td>
<td>Anesthesiologist</td>
<td>(Base Units) + (Time Units) / 15 x conversion factor x 0.632</td>
</tr>
<tr>
<td></td>
<td>QY</td>
<td>Medical direction of one CRNA / AA by an anesthesiologist</td>
<td>Anesthesiologist</td>
<td>(Base Units) + (Time Units) / 15 x conversion factor x 0.632</td>
</tr>
<tr>
<td></td>
<td>QX</td>
<td>CRNA service with medical direction by a physicians</td>
<td>CRNA</td>
<td>(Base Units) + (Time Units) / 15 x conversion factor x 0.632</td>
</tr>
<tr>
<td>Resident - Teaching Facility</td>
<td>GC</td>
<td>Services performed by a Resident under the direction of a teaching physician</td>
<td>Anesthesiologist</td>
<td>(Base Units) + (Time Units) / 15 x Conversion Factor</td>
</tr>
</tbody>
</table>

The GC modifier is reported by the teaching physician. MHCP will reimburse anesthesiologists for supervision of residents, following Medicare requirements and restrictions. If the teaching anesthesiologist is involved in a single case with an anesthesia 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
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</table>
|                       | G8       | Monitored anesthesia care (MAC) for deep complex, complicated or markedly invasive surgical procedures | Anesthesiologist, CRNA | Same as Medicare  
• 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 | Same as Medicare See above. |
|                       | QS       | Monitored Anesthesia Care | Anesthesiologist, CRNA | See Above |
|                       | 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 severe systemic disease | NA | Informational only; does not impact payment |
|                       | P4       | A patient with severe 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 | NA | Informational only; does not impact payment |
Provider Payment Policy

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<tr>
<th>ANESTHESIA OVERSIGHT</th>
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</thead>
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<tr>
<td></td>
<td></td>
<td>donor purposes</td>
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**PRIOR AUTHORIZATION OR THRESHOLD LIMITS**

There is no prior authorization or threshold limits associated with anesthesia services.

**RELATED PAYMENT POLICY DOCUMENTATION**

**REFERENCES TO OTHER PAYMENT POLICY DOCUMENTATION THAT MAY BE RELEVANT TO THIS POLICY.**

<table>
<thead>
<tr>
<th>POLICY NUMBER</th>
<th>POLICY DESCRIPTION AND LINK</th>
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**REFERENCES AND SOURCE DOCUMENTS**

**LINKS TO CMS, MHP, MINNESOTA STATUTE AND OTHER RELEVANT DOCUMENTS USED TO CREATE THIS POLICY.**

- **MHCP Provider Manual, Anesthesia Services, Last Revised 07/20/2015**
- **IOM-04 Medicare Claims Processing Manual, Chapter 12 Physician/NonPhysician Practitioners, Section 50**

Teaching