UnitedHealthcare® Medicare Advantage
Reimbursement Policy
CMS 1500
Policy Number 2025R9008A

Anesthesia Services Policy, Professional

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 Medicare Advantage 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. 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 Medicare Advantage reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Medicare Advantage 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 Medicare Advantage 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 Medicare Advantage due to programming or other constraints; however, UnitedHealthcare Medicare Advantage strives to minimize these variations.

UnitedHealthcare Medicare Advantage may modify this reimbursement policy at any time to comply with changes in CMS policy and other national standard coding guidelines by publishing a new version of the reimbursement policy on this website. However, the information presented in this reimbursement policy is accurate and current as of the date of publication. UnitedHealthcare Medicare Advantage encourages physicians and other health care professionals to keep current with any CMS policy changes and/or billing requirements by referring to the CMS or your local carrier website regularly. Physicians and other health care professionals can sign up for regular distributions for policy or regulatory changes directly from CMS and/or your local carrier. UnitedHealthcare's Medicare Advantage reimbursement policies do not include notations regarding prior authorization requirements.

** For more information on a specific enrollee's benefit coverage, please call the customer service number on the back of the member ID card.

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Application

This reimbursement policy applies to all Medicare Advantage products and for 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 network physicians and other qualified health care professionals.

Policy

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 Health Care 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

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

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

Modifiers

Required Anesthesia Modifiers
All anesthesia services including Monitored Anesthesia Care must be submitted with a required anesthesia modifier in the first modifier position. These modifiers identify whether a procedure was personally performed, medically directed, or medically supervised. Consistent with CMS, UnitedHealthcare Medicare Advantage will adjust the Allowed Amount by the Modifier Percentage indicated in the table below.

Required Anesthesia Modifiers	Reimbursement Percentage	Provider type
AA	100%	Anesthesiologist MD Personally Performed
AD	100%	Anesthesiologist MD Supervising over 4
QK	50%	Anesthesiologist MD Supervising 2-4

QX	50%	CRNA or AA Directed by Anesthesiologist MD
QY	50%	Anesthesiologist MD Supervising 1
QZ	100%	CRNA Personally Performed

These CPT and HCPCS modifiers may be reported to identify an altered circumstance for anesthesia and pain management. If reporting CPT modifier 23 and 47 or HCPCS modifiers GC, G8, G9 or QS, no additional reimbursement is allowed above the usual fee for that service.

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

NOTE: Physical Status Modifiers: Physical status modifiers are not recognized by Medicare.

Reimbursement Formula

Base Values:
Each CPT anesthesia code is assigned a Base Value by the ASA, and UnitedHealthcare Medicare Advantage 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 Advantage requires time-based anesthesia services be reported with actual Anesthesia Time in one-minute increments. For example, if the Anesthesia Time is one hour, then 60 minutes should be submitted.

The ASA indicates that post- surgical pain blocks are frequently placed before anesthesia induction or after anesthesia emergence. When the block is placed before induction or after emergence, the time spent placing the block should not be added to the reported Anesthesia Time; this is true even if sedation and monitoring is provided to the patient during block placement.

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

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

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

*For additional information, refer to Modifiers.

Qualifying Circumstances
Qualifying circumstances codes identify conditions that significantly affect the nature of the anesthetic service provided. Consistent with CMS guidelines, UnitedHealthcare Medicare Advantage does not allow additional base units for qualifying circumstance codes. The qualifying circumstances codes are 99100, 99116, 99135 and 99140.

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.

Code 01953 is an add-on-code and is used in conjunction with code 01952. Codes 01968 and 01969 are add-on-codes and are used in conjunction with code 01967. 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 Advantage will only reimburse the first submission of that code. However, anesthesia administration services can be rendered simultaneously by an MD and a CRNA during the same operative session, each receiving 50% of the Allowed Amount (as indicated in the Modifier Table above) by reporting modifiers QK or QY and QX.

In the event an anesthesia administration service is provided during a different operative session on the same day as a previous operative session, UnitedHealthcare Medicare Advantage will reimburse one additional anesthesia administration appended with modifier 59, 76, 77, 78, 79, XE, XP or XU. As with the initial anesthesia administration, only the single anesthesia code with the highest Base Unit Value should be reported.

Anesthesia and Procedural Bundled Services

UnitedHealthcare Medicare Advantage 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 Medicare Advantage 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 Advantage 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.

Payment for Medical and Surgical Services Furnished in Addition to Anesthesia Procedure

Payment may be made under the fee schedule for specific medical and surgical services furnished by the anesthesiologist as long as these services are reasonable and medically necessary or provided that other rebundling provisions (see §30 and Chapter 23) do not preclude separate payment. These services may be furnished in conjunction with the anesthesia procedure to the patient or may be furnished as single services, e.g., during the day of or the day before the anesthesia service. These services include the insertion of a Swan-Ganz catheter, the insertion of central venous pressure lines, emergency intubation, and critical care visits.

Definitions	
Allowable Amount	Defined as the dollar amount eligible for reimbursement to the physician or other qualified health care professional on the claim. Contracted rate, reasonable charge, or billed charges are examples of an Allowable Amount, whichever is applicable. For percent of charge or discount contracts, the Allowable Amount is determined as the billed amount, less the discount.
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.
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.

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.
Base 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
Modifier Percentage	Reimbursement percentage allowed for anesthesia services which are personally performed, medically directed or medically supervised as defined by the modifier (i.e., 50% for the modifier QK).
Monitored Anesthesia Care	Per the ASA Monitored Anesthesia Care includes all aspects of anesthesia care – a 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: • Diagnosis and treatment of clinical problems that occur during the procedure • Support of vital functions • Administration of sedatives, analgesics, hypnotics, anesthetic agents or other medications as necessary for patient safety • Psychological support and physical comfort • Provision of other medical services as needed to complete the procedure safely. Monitored Anesthesia Care may include varying levels of sedation, analgesia and anxiolysis as necessary. The provider of Monitored Anesthesia Care must be prepared and qualified to convert to general anesthesia when necessary. Modifiers G8, G9 and QS are used to identify Monitored Anesthesia Care.
Same Individual Physician or Other Qualified Health Care Professional	The same individual rendering health care services reporting the same National Provider Identifier (NPI) 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 Medicare Advantage requires time-based anesthesia services be reported with actual Anesthesia Time in one-minute increments.

Questions and Answers	
1	**Q:** How should anesthesia services performed by the Anesthesia Professional be reported when the medical or surgical procedure is performed by a different physician or other qualified health care professional? **A:** For general or monitored anesthesia services, in support of a non-anesthesia service, please refer to the ASA CROSSWALK® and report the appropriate CPT anesthesia code (00100 - 01999).

2	**Q:** How should anesthesia services performed by the same physician who also furnishes the medical or surgical procedure be reported? **A:** If a physician personally performs the anesthesia for a medical or surgical procedure that he or she also performs, modifier 47 would be appended to the medical or surgical code, and no codes from the anesthesia section of the CPT codebook would be used.
3	**Q:** How should anesthesia services be reported when surgery has been cancelled? **A:** If surgery is cancelled after the Anesthesia Professional has performed the preoperative examination but before the patient has been prepared for the induction of anesthesia, report the appropriate Evaluation & Management code for the examination only. If surgery is cancelled after the Anesthesia Professional has prepared the patient for induction, report the most applicable anesthesia code with full base and time. The Anesthesia Professional is not required to report the procedure as a discontinued service using modifier 53.
4	**Q:** How should a CRNA report anesthesia services? **A:** CRNA services should be reported with the appropriate anesthesia modifier QX or QZ. CRNA services must be reported under the supervising physician's name or the employer or entity name under which the CRNA is contracted. In limited circumstances, when the CRNA is credentialed and/or individually contracted by UnitedHealthcare Medicare Advantage, CRNA services must be reported under the CRNA's name.
5	**Q:** How should a teaching anesthesiologist report anesthesia services for two resident cases? **A:** Consistent with CMS policy, the teaching anesthesiologist may report the actual Anesthesia Time (see definitions) for each case with modifiers AA and GC.
6	**Q:** When modifier PT is billed does the member have a cost share? **A:** Coinsurance and deductible does not apply to anesthesia claim lines furnished in conjunction with screening colonoscopy services with modifier PT

Resources

www.cms.gov

American Medical Association (AMA) Current Procedural Terminology (CPT®)

American Society of Anesthesiologists (ASA): Relative Value Guide®

Medicare Claims Processing Manual - Chapter 12 - Physicians/Nonphysician Practitioners: Section 50, 100, 140

National Correct Coding Initiative Edits: NCCI Policy Manual for Medicare - Chapters I and II

The Medicare Learning Network (MLN) - MLN Matters: MM5618 and MM8874

History

2/1/2025	Policy Version Change Resource Section: Updated Policy History Section: Entries prior to 2/1/2023 archived
2/1/2024	Policy Version Change Policy History Section: Entries prior to 2/1/2022 archived
8/22/2023	Policy Version Change Policy Logo Updated

	Policy Definitions Section: Updated Policy History Section: Entries prior to 8/22/2021 archived
2/15/2023	Policy Version Change Application Section: Updated History Section: Entries prior to 2/15/2021 archived
8/27/2014	New Policy