Commercial Reimbursement Policy

Subject: **Anesthesia Services – Professional**	
Policy Number: **C-09002**	Policy Section: **Anesthesia**
Last Approval Date: **11/26/2024**	Effective Date: **03/01/2025**

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by an Anthem Blue Cross and Blue Shield (Anthem) member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

Policy

The Health Plan allows reimbursement for anesthesia services rendered by professional providers based upon:

- American Society of Anesthesiologists (ASA) anesthesia formula unless otherwise noted in the exemption section.
- Proper use of applicable modifiers.
- Additional factors such as field avoidance and unusual positioning.

Services involving the administration of anesthesia are reported by using anesthesia codes and, if applicable, a physical status modifier and/or a servicing modifier.

I. Time

Providers must report anesthesia services in one-minute increments and note in the units field. Anesthesia claims submitted with an indicator other than minutes may be rejected or denied. Start and stop times must be documented in the member's medical record. Anesthesia time starts with the preparation of the member for administration of anesthesia and stops when the anesthesia provider is no longer in personal attendance. Anesthesia time can be counted in blocks of time if there is an interruption in anesthesia, as long as the time counted is that in which continuous anesthesia services are provided.

Time spent performing anesthesia services is reported in one-minute increments and noted in the unit's field. Providers should report time units only, as base units are automatically added by the health plan. To calculate reimbursement for time, the number of minutes reported is divided by 15 (minutes) and rounded up to the next unit. **

**Example: 61 minutes divided by15 = 4.0666 units. Reimbursement for time will be rounded to 5 units.

The allowance for reimbursement of anesthesia services rendered is calculated by adding the time units to the base units assigned to the anesthesia code reported and multiplying that sum by the contracted conversion factor. **

**In the example given above, the time units would be 5. If the anesthesia code had a base unit of 5, then 5 added to 5 would give a reimbursement measure of 10. If the anesthesia allowance was $50, then 10 x $50 would =$500.

II. Anesthesia Modifiers

Anesthesia modifiers are appended to the applicable procedure code to indicate the specific anesthesia service or to indicate who performed the service. Modifiers identifying who performed the anesthesia must be billed in the primary modifier field to receive appropriate reimbursement. Claims submitted for anesthesiology services without the appropriate modifier will be denied. The total reimbursement for anesthesia services provided by a physician/anesthesiologist and a non-physician anesthesia provider will not exceed 100% of the eligible amount that would be allowed had the anesthesia service been provided by only the physician/anesthesiologist. Please note specific anesthesia modifiers located in the related coding section below.

Physical Status Modifiers

Physical Status Modifiers identify a specific physical condition, which indicates an added level of complexity to the anesthesia service provided. Anthem follows the ASA recommendation that unit values are assigned to the following physical status modifiers for additional reimbursement when appended to the base anesthesia code. Please note specific anesthesia modifiers located in the related coding section below.

The following physical status modifiers will receive additional reimbursement, as noted below, when appended to the base anesthesia code, and accompanied with a servicing modifier.

- Modifier P3 = 108% (A patient with severe systemic disease)
- Modifier P4 = 112% (A patient with severe systemic disease that is a constant threat to life)
- Modifier P5 = 116% (A moribund patient who is not expected to survive without the operation)
- The Health Plan recognizes the following physical status modifiers, when accompanied with a servicing modifier, but no additional reimbursement is allowed.
- Modifier P1 = A normal, healthy patient
- Modifier P2 = A patient with mild systemic disease
- Modifier P6 = A declared brain-dead patient whose organs are being removed for donor purposes

III. Multiple Procedures
Based on ASA billing guidelines, when anesthesia services are provided for multiple surgical procedures, only the anesthesia procedure code for the most complex service should be reported. Base units are only used for the primary procedure and not for any secondary procedures. If two separate anesthesia codes are reported, the procedure with the lesser charge will be denied. (Exception: Add-on codes 01953, 01968, or 01969, which are listed separately in addition to the code for the primary procedure, are eligible for separate reimbursement.)

If the Health Plan can determine, based on its review of the anesthesia record, that a separate subsequent operative session took place with more than an hour separation from the initial anesthesia, the second subsequent anesthesia service may be considered eligible for separate reimbursement.

IV. Field Avoidance and Unusual Positioning
The Health Plan allows any procedure around the head, neck, or shoulder girdle, requiring field avoidance, or any procedure requiring a position other than supine or lithotomy, to have a minimum base value of 5 regardless of any lesser base value assigned to such procedure.

Unusual positioning is not eligible for additional reimbursement even when reported with modifier 22.

V. Qualifying Circumstances for Anesthesia
The Health Plan considers qualifying circumstances to be always bundled when reported in addition to the anesthesia procedure or service provided.

The following CPT codes identify qualifying circumstances:
- 99100 Anesthesia for patient of extreme age, younger than 1 year and older than 70.
- 99116 Anesthesia complicated by utilization of the total body hypothermia.
- 99135 Anesthesia complicated by utilization of controlled hypotension.
- 99140 Anesthesia complicated by emergency conditions.

VI. Anesthesia for Oral Surgery

The Health Plan allows reimbursement for anesthesia for covered oral surgical procedures reported with appropriate CDT based anesthesia codes (D9211 - D9248).
We do not allow reimbursement for anesthesia rendered during oral surgery when the same claim is reported with both CPT and CDT codes as follows:

- CPT anesthesia codes 00170 - 00176 which describes anesthesia for intraoral procedures will not be eligible for reimbursement when reported with a CDT procedures.
- CDT anesthesia codes D9211 - D9248 will not be eligible for separate reimbursement when reported with CPT procedure codes.

The Health Plan requires an oral surgeon reporting services with a CPT procedure and also provides an anesthesia service to append modifier 47. In this instance, there is no additional reimbursement for the anesthesia. Only the oral surgery procedure is eligible for reimbursement.

VII. Services Included/Excluded in the Global Reimbursement for Anesthesia

Global reimbursement for the anesthesia service provided includes all procedures integral to the successful administration of anesthesia from the initial pre-anesthesia evaluation through the time when the anesthesiologist or other qualified health care professional in the same anesthesia provider group is no longer in personal attendance. In accordance with NCCI coding guidelines, the Health Plan considers the following services **included** in global reimbursement for anesthesia services and are **not** eligible for separate reimbursement:

- Daily hospital management of patient-controlled analgesia (when a patient controls the amount of analgesia he or she receives).
- Echocardiography.
- Electroencephalogram.
- Inhalation treatments.
- Laryngoscopy and bronchoscopy procedures.
- Placement and interpretation of any non-invasive monitoring, which may include ECG testing monitoring of temperature/blood pressure/pulse oximetry carbon dioxide, expired gas determination by infrared analyzer/capnography) and mass spectrometry, and vital capacity.
- Placement of endotracheal and naso-gastric tubes.
- Placement of peripheral intravenous lines and administration of fluids, anesthetic or other medications through a needle or tube inserted into a vein.
- Venipuncture and transfusion.

The Health Plan considers one-day preoperative evaluation and management (E/M) services and 10-day postoperative E/M services; the 10-day postoperative period includes any E/M services that are a follow-up to the general anesthesia service, as well as any E/M services related to postoperative pain management for the surgical episode. The 10-day postoperative period will apply to the anesthesiologist or other qualified health care professional who performed the general anesthesia, or to other providers in the same anesthesia provider group. Nerve block injections (for pain management) will be eligible for separate reimbursement.

When an anesthesiologist, a non-physician anesthesia provider, an anesthesia group, or any other professional provider, separately reports a medication in a facility setting, the medication will not be eligible for separate reimbursement even when reported with an unclassified or unspecified drug code. The Health Plan considers the provision of any medication, including Propofol, to be included under the facility's charge.

The Health Plan allows separate reimbursement for the following services provided in conjunction with anesthesia procedures:

- Swan-Ganz catheter insertion.
- Central venous pressure line insertion.
- Intra-arterial lines.
- Transesophageal echocardiography (TEE):
  - In accordance with National Correct Coding Initiative (NCCI) coding guidelines, the Health Plan requires that if a transesophageal echocardiography (TEE) is performed as a distinct and independent procedure from the anesthesia service provided, then the appropriate modifier must be appended to the TEE code in the code range of 93312-93317 to be eligible for separate reimbursement.
  - If TEE services are for monitoring purposes (e.g., CPT code 93318) or guidance of a transcatheter intracardiac or great vessel(s) structural intervention(s) (e.g., CPT code 93355), the Health Plan will follow NCCI edit logic and consider the codes incidental and a bypass modifier will not override.

VIII. Postoperative Pain Management

- Postoperative pain management services by an anesthesiologist, such as an injection or catheter insertion into the epidural space or major nerve, are eligible for separate reimbursement. Postoperative pain management services are eligible for reimbursement and time units are not applicable. This applies to the following codes and ranges: 62320-62327, 64400-64450.
- When postoperative pain management services are performed bilaterally, the unilateral code must be reported once with modifier 50 using the applicable base value for the unilateral code. The pain management code will be considered as one surgical service and will be eligible for reimbursement equal to 150% of the allowance for the code.
- An epidural or major nerve injection or catheter insertion performed by an anesthesiologist for postoperative pain management before, during, and/or following the surgical procedure is eligible for separate reimbursement in addition to the primary anesthesia code. The appropriate modifier must be appended to the appropriate procedure code to indicate a distinct procedural service was performed.
- The daily hospital management of epidural or subarachnoid continuous drug administration (CPT code 01996) for postoperative pain management performed by the anesthesiologist is eligible for reimbursement once per date of service following the surgery date. However, when the daily management code is reported with an anesthetic injection code such as CPT codes 62320-62327, only the injection code is eligible for reimbursement. Modifiers will not override the edits.

- The Health Plan will deny daily hospital management of epidural or subarachnoid continuous drug administration procedure code when billed with a physical status modifier or qualifying circumstance procedure codes.

Related Coding

Description	Coding Grids
Anesthesia Modifiers	Anesthesia Modifiers

Policy History

11/26/2024	Review approved 11/26/2024 and effective 03/01/2025: • updated policy title from Professional Anesthesia Services • updated language for qualifying circumstances to always bundle • added modifier G8, G9, QS to code list in the Related Coding section • added Physical Status modifiers language
06/18/2021	Review approved: minor administrative changes
11/16/2018	Review approved: updated policy language in all sections
02/07/2017	Review approved: deleted duplicate entries of routine maternity diagnoses O34.21 and O82 and put codes in sequential order. Remove deleted codes and add 2017 codes for spinal injections (62320-62327) under “Pain Management” section; no change to editing concept
09/06/2016	Review approved: updated policy language; clarified services reported by both MD and midlevel will not allow more than 100% of allowable amount; removed ICD-9 codes; removed 64412 under post-op pain management section; code deleted in 2016
01/05/2016	Review approved: updated policy language; added back language that modifiers G8, G9, and QS are informational and are to be reported in a subsequent modifier field when reported with a servicing modifier
12/01/2015	Review approved: policy language updated: included modifiers G8, G9, QS (Monitored anesthesia care) in the modifiers table stating that the use of these modifiers with general anesthesia codes will cause the anesthesia service to deny; the modifiers are informational only and do not apply any pay percent; we are removing the line under the modifier table that states these modifiers may be reported in a subsequent modifier field
05/05/2015	Review approved: updated policy language; included the new 2015 transesophageal echocardiography (TEE) code 93355 as not allowed with an anesthesia service, that we follow NCCI logic for this code the same as we do for TEE code 93318—superscript of “0” not allowed with the primary service (anesthesia) and modifier will not override; Also on the same page, bullet 6.d., updating the grammar for professional provider separately reporting charges for medication in a facility setting, the medication is not eligible for reimbursement; updated the diagnosis

	table to make cleaner (as was done in the Routine OB policy presented last month)
11/04/2014	Review approved: updated name of policy to add “Services” to the title (Anesthesia Services); updated language under the Servicing Modifiers section on pg. 2; does not change any criteria or edits; updating language to include the phrase “postoperative” since this section truly does address postoperative pain management services; no criteria or edit changes are associated with this update
04/01/2014	Review approved: updated policy language; updated the routine OB diagnosis code table to include ICD-10 codes along with minor non-substantive updates to punctuation, grammar throughout the policy.
06/04/2013	Review approved: updated grammatical changes and policy language
03/05/2013	Review approved: updated policy language; updated coding section
09/11/2012	Review approved: updated policy language; expanded language for modifier AS in the coding table: updated coding section
09/13/2011	Review approved: updated policy language
08/10/2011	Review approved: updated policy language for OB services
06/21/2011	Review approved: updated footnote reference from RV Guide from 2009 to 2010
06/07/2011	Review approved: added modifier reduction for QK, QX and QY; updated coding section
03/08/2011	Review approved: updated formatting changes to eliminate mark-ups
10/05/2010	Review approved: updated minor language
08/03/2010	Review approved: updated Coding section
07/06/2010	Review approved: updated policy language
12/14/2009	Review approved: updated policy language
09/14/2009	Review approved: updated Heading and policy history section with new format
04/17/2009	Review approved: updated policy language
02/03/2009	Initial approval and effective

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- Optum EncoderPro 2024

Definitions

Anesthesia	Refers to the drugs or substances that cause a loss of consciousness or sensitivity to pain
Base Units (BU)	Base Units (BU) are assigned to a specific anesthesia CPT code and are derived from the American Society of Anesthesiologists (ASA) Anesthesia Relative Value Guide (RVG)
Conversion Factor (CF)	A geographic-specific amount that varies by the locality where the anesthesia is administered

General	Drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation.
Local	Loss of sensation in a limited and superficial area of the body
Regional	Delivery of anesthetic medication at a specific level of the spinal cord and/or to peripheral nerves is used when loss of consciousness is not desired but sufficient analgesia and loss of voluntary and involuntary movement is required
Time Units (TU)	An increment of fifteen (15) minutes where each 15-minute increment constitutes one (1) time unit
General Reimbursement Policy Definitions	

Related Policies and Materials

Global Surgical Package - Professional
Modifier Usage - Professional
Scope of License - Professional

Use of Reimbursement Policy

This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a member's benefits on the date of service. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.