Policy Information			
Policy Title	Anesthesia Services	**Current Version Publish Date**	10/2025
Policy Manual	Provider Reimbursement Policy Manual	**Original Effective Date**	10/2025
Policy Number	3	**Next Review Date**	Annual

Policy Applicability (LOB)			
☒Medicare Inc ☒Medicare WI	☒Commercial IA ☒Commercial WI	☒Commercial IL ☒CPPHP (Kansas)	☒Health Choices

Policy Statement and Purpose

This policy addresses the criteria for reimbursement for the anesthesia services indicated herein. The stipulations are based on CMS coding and payment requirements. Adhering to these guidelines does not imply payment, only eligibility for reimbursement. Actual payment for services will be guided by the services documented in the medical record and the coverage criteria in the patient's contracted medical plan for whom the services are rendered.

This policy is expressly incorporated into and made a part of all reimbursement agreements and will provide context and clarity to the extent there is ambiguity in payment terms and notwithstanding contrary claims with regard to industry standards or practices.

Policy Definitions

The terms described below will define their meaning and intent as it pertains to eligibility for reimbursement and payments made under this policy. In the event of legal or professional differences, the definitions for the terms stated herein will prevail notwithstanding, and requisite payment actions will be made accordingly.

Add-on Code (AOC): Describes a service or procedure performed in addition to a primary service. Add-on Codes must be paired with a primary procedure code.

Anesthesia Assistant: A qualified healthcare professional with applicable state licensure where recognized that works under the direction of a licensed anesthesiologist to design and implement anesthesia care plans.

BSER: Brainstem-evoked Response

CMS: Centers for Medicare and Medicaid Services

CMS-1500: A standard claim form used by non-institutional providers for reimbursement of professional medical services.

CPT: Current Procedural Terminology. A medical code set maintained by the American Medical Association (AMA) that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations. CPT is included in Level I Healthcare Common Procedure Coding System (HCPCS).

CRNA: Certified Registered Nurse Anesthetist

EDI 837P: This is a transaction set for the submission of professional claims that ensures all necessary data is included to provide accurate payment.

EEG: Electroencephalography

E/M: Evaluation and Management

General Anesthesia: Drug-induced loss of consciousness where patient cannot awaken, even with painful stimuli.

Global Period: The period of time before a surgical procedure and after the procedure has been performed. The global period varies and is based on the nature of the procedure.

HCPCS: Healthcare Common Procedure Coding System.

Local Anesthesia: Prevents painful sensation to a specific area. Also known as topical anesthesia.

Moderate Sedation: A drug induced depression of consciousness during which the patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation.

Monitored Anesthesia Care (MAC): Intra-operative monitoring by a physician or qualified healthcare practitioner under the medical direction of a physician of the patient's vital signs in anticipation for the need of general anesthesia or of the development of an adverse reaction to or during the surgical procedure. It also includes the performance of a pre-anesthesia examination, writing orders for the anesthesia care required, administration of pre-anesthesia oral or parenteral medications, and postoperative anesthesia care.

Modifier: Two characters (letters or numbers) appended to a CPT or HCPCS Level II code. The modifier provides additional information about the medical procedure, service, or supply involved without changing the meaning of the code.

Modifier 51: Indicates that multiple procedures were performed during the same session by the same provider.

Outpatient Prospective Payment System (OPPS): A reimbursement system used by CMS to determine payments for hospital outpatient services.

PACU: Post Anesthesia Recovery Unit

Preoperative Anesthesia Evaluation: Includes a sufficient history and physical examination so that the risk of adverse reactions are minimized, alternative approaches to anesthesia planned, and all questions regarding the anesthesia procedure by the patient or family are answered.

Qualified Healthcare Professional: Physician assistant or clinical nurse specialist who is not a licensed M.D. or D.O. or nurse practitioner.

Qualified Healthcare Practitioner: Individual who is qualified by education, training, licensure/regulation (when applicable) and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.

Regional Anesthesia: Performed as a single injection or with a continuous catheter in which medication is given over a prolonged period.

Revenue Code: A three or four digit numeric code used to categorize the location or department for a type of service, procedure, or item provided to a patient within a healthcare facility.

UB-04: A standardized medical billing form used by facility providers to submit claims for reimbursement to insurance companies and governmental entities. It is also known as the CMS-1450.

Unbundling: Reporting multiple HCPCS/CPT codes when a single code exists for the services performed.

Policy Provisions and Required Procedures

The continuum of anesthesia services range in complexity and include local anesthesia, moderate (conscious), regional anesthesia and general anesthesia. This policy addresses the billing requirements for those anesthesia services for both professional and facility claims.

Who is eligible for reimbursement for anesthesia services?
Anesthesiologists, CRNAs with or without medical direction, and Anesthesia Assistants under the medical direction of an anesthesiologist are eligible for reimbursement.

What is included in the anesthesia care package?
The anesthesia care consists of preoperative evaluation, standard preparation and monitoring services, administration of anesthesia, and post-anesthesia recovery care. These services are not eligible for separate reimbursement.

What situations are anesthesia services not eligible for separate reimbursement?
Anesthesia services are not eligible for separate reimbursement when:

- Provided by a physician or surgeon who performs the procedure.
- Provided by a registered nurse or under the direction of the physician or surgeon who performs the procedure.
- Performed under OPPS

What services are not eligible for separate reimbursement when anesthesia care is being delivered?
Services that are integral to anesthesia care are not separately payable. Examples include, but are not limited to, the following:

- Preoperative evaluation and examination
- Post operative evaluation, examination and care
- Intra-operative monitoring (O2, BP, CO2, EEG, ECG, etc.)
- Ventilator setup and management
- Ventilator management post operatively
- Transporting
- Positioning
- Placement of external devices (cardiac, oximetry, capnography, temperature, EEG, BSER, Doppler flow)
- Placement of peripheral intravenous lines
- Placement of airway
- Placement of gastric tube
- Nerve stimulation for determination of paralysis or nerve localization
- Insertion of urinary bladder catheter
- Sample procurement regardless of the mode of collection

What services are allowable under extenuating circumstances?
If a surgery is canceled after the preoperative evaluation has been performed, the anesthesiologist or CRNA may be eligible for payment when the service is billed under an appropriate E/M CPT.

Post operative pain management and ventilator management that is significant and separately identifiable may be eligible for separate reimbursement when unrelated to the anesthesia procedure. The medical record must clearly identify the circumstances and the actions taken by the anesthesiologist/CRNA.

Anesthesia Types/Circumstances and Reimbursement Guidelines

Local (Topical) Anesthesia

Local anesthesia is not eligible for reimbursement. It is bundled into the procedure for which the anesthesia is required.

Moderate Sedation (CPT 99151-99153)

Moderate conscious sedation services are eligible for separate reimbursement when provided by the same physician performing a medical or surgical procedure except when the anesthesia service is bundled into the procedure (radiation treatment management).

Report the appropriate CPT code that describes the moderate sedation services provided to the patient in conjunction with the procedural service rendered. Under no circumstances will moderate sedation be eligible for reimbursement if a procedural CPT is not billed on the same claim for the same date of service.

Monitored Anesthesia Care (MAC)

Monitored anesthesia care requires continuous evaluation of vital physiological functions including the recognition and treatment of any adverse changes during a procedure. Reasonable charges for medically necessary monitored anesthesia care are separately reimbursable in addition to the anesthesia services when modifier QS is appended to the code for the service charge. Monitored anesthesia care that is provided by qualified healthcare practitioners other than an anesthesiologist or CRNA is eligible for payment as follows:

- Surgeon/physician personally performs the monitored anesthesia care case when continuously involved with a single case.
- Surgeon/physician medically directs four or fewer concurrent cases and monitored anesthesia care represents one or more of these concurrent cases, payment will be 50 percent of the allowance had the service been performed by the surgeon/physician alone.

Medical and Surgical Services Provided in Addition to Anesthesia Procedure

If an anesthesiologist or CRNA provides medical or surgical services that are reasonable and medically necessary, such services may be eligible for reimbursement. These services may be provided in conjunction with the anesthesia procedure or may be provided as a single service the day of or the day before the anesthesia service. These services include:

- Insertion of a Swan Ganz catheter
- Insertion of central venous pressure lines
- Emergency intubation
- Critical care visits

Multiple Anesthesia Procedures

When reimbursement is related to anesthesia services associated with multiple surgeries the physician should report the anesthesia procedure with the highest base unit value and append modifier -51. Report the total time for all procedures.

Multiple Anesthesia Providers

When the services of multiple anesthesiologists are required, the anesthesiologist spending the most time during the procedure should submit a claim for the entire case. If all anesthesiologists spent the same amount of time on a particular procedure, the anesthesiologist who started the case should submit the claim for the entire case. Documentation must include the names of all physicians involved and the total time for all anesthesia procedures.

Obstetrical

Personal attendance by an anesthesiologist or CRNA is generally not required throughout the procedure. Report the services for neuraxial analgesia with CPT 01967 – 01969. Services for these codes are paid according to the stipulations of the provider contract. .

Diagnostic or Therapeutic Nerve Blocks

- Different providers: Anesthesiologist/CRNA provides anesthesia for diagnostic or therapeutic nerve blocks or injections, but a different provider performs the block or injection: Anesthesiologist/CRNA should report the anesthesia service using the appropriate CPT code.
    - The service must meet the criteria for Monitored Anesthesia Care defined above.

- Same provider: Anesthesiologist/CRNA provides both the anesthesia service and the block or injection: Anesthesiologist/CRNA report the anesthesia service and the injection or block.
    - If a lower level complexity anesthesia service is provided such as local or topical anesthesia, then the moderate sedation code should not be reported as the service is not eligible for reimbursement.

- Continuous Drug Administration during epidural or subarachnoid drug administration (CPT 01996):
    - Only an anesthesiologist or CRNA that is nonmedically directed may report this code.
    - This service is separately payable on dates of service after surgery but not on the date of surgery.
    - Do not report an E/M service in addition to CPT 01996.
    - Payment is limited to **one unit of service per postoperative day** regardless of the number of visits required to manage the catheter and mode of administration (bolus, intermittent bolus, continuous).
    - Time units should not be reported for CPT 01996.
    - Catheter placement for continuous infusion for intraoperative pain management is included in the anesthesia procedure and is not separately reportable on the same date of service even if it also provides post operative pain management.

- Post operative pain management via epidural or peripheral nerve block (CPT 62320-62327 or 64400-64530):
    - May be eligible for separate payment by the anesthesiologist or CRNA if general anesthesia, subarachnoid injection or epidural was the mode of intraoperative anesthesia. Administration may be preoperatively, intraoperatively, or postoperatively.
    - Epidural or nerve block is not separately payable if the mode of anesthesia for the procedure is monitored anesthesia care, moderate conscious sedation, regional anesthesia by peripheral nerve block.
    - Postoperative pain management by the physician performing a surgical procedure is a component of the global surgical package and is not separately payable.

Calculating Anesthesia Time

Anesthesia time is a continuous time period. Anesthesia care begins during the period which a qualified anesthesia practitioner assumes responsibility for the patient and begins to prepare the patient for anesthesia services in the operating room or an equivalent area. Anesthesia time ends when the anesthesia practitioner hands off the patient to PACU or for post-operative care. Interruptions in anesthesia time are eligible for reimbursement provided the patient remains in the care of the anesthesia provider and this is corroborated in the medical record.

- Example: An anesthesiologist is administering a sedative in conjunction with a regional block to a patient for a cataract extraction. There is an interval of 30 minutes in which the patient does not require monitoring by the anesthesiologist. This interval of time is not included in the anesthesia time calculation.

Billing for Anesthesia Services

Providers should report the CPT or HCPCS code that describes the service rendered to the greatest specificity. Providers should not report more than one CPT/HCPCS code if a single code exists for the services performed and services should not be unbundled simply because a code exists. Instances of unbundling will be denied as incorrect coding.

CMS Status B codes are qualifying circumstances and are always bundled into the payment for other services. These codes are not eligible for reimbursement. Status B codes are listed in the CMS NPFS Relative Value File release available on the CMS website.

Professional Claims

- Claim Submission: Electronic Claims
  Submit the claim via the EDI 837P transaction set. Report total minutes in loop 2400 SV 104 with MJ qualifier in loop 2400 SV 103.
- Claims Submission: Paper Claims
  Submit the claim on a CMS-1500 form. Enter the details of the anesthesia services on line 24 A-K. For line 24G enter the total anesthesia time in minutes. See *Calculating Anesthesia Time* above for calculating time units.

- Calculating Payment for Professional Reimbursement
  The standard anesthesia formula for calculating reimbursement is as follows:
  [(Base Units[1] + Time units[2]) x Anesthesia Rate] x Modifying Factor[3]

  [1]**Base Unit:** Medical Associates Health Plan aligns with the Base Unit Value as defined by CMS. These values are updated annually and may change from year to year.

  [2]**Time Units:** We will divide the total minutes that you report on your claim into 15-minute increments unless otherwise stated in our contract with you. For fractional units we will round up.

  [3]**Modifying factors** are used when there are elements that influence the complexity and the resources needed for extremely complex cases. If the provider's contract specifically stipulates the use of Modifying Factors when calculating anesthesia reimbursement, the factors are as follows:
  - P1 (normal healthy patient) = 0 units
  - P2 (mild systemic disease) = 0 units
  - P3 (severe systemic disease) = 1 unit
  - P4 (severe systemic disease that is a constant threat to life) = 2 units
  - P5 (a moribund patient who is not expected to survive without the operation) = 3 units
  - P6 (declared brain-dead patient organs are being removed for donor purposes) = 0 units

  Facility Claims
  Anesthesia services should be billed on a UB-04 using revenue code 0370 and the appropriate CPT code. Time should be entered in minutes. See *Calculating Anesthesia Time* above for calculating time units. The time reported on the UB-04 must reconcile with the time reported in the itemized bill. If these do not reconcile, the service is ineligible for payment.

  Teaching and Supervision
  All charges for services rendered while either teaching or supervising must have the appropriate modifier appended to the anesthesia service charge. Medical Associates Health Plan adheres to CMS Modifier Percentages as indicated in the *Anesthesia Claim Modifier* section below. Charges for anesthesia care submitted by the following health professionals are not eligible for reimbursement regardless of the modifier appended to the charge:
  - Residents
  - Student nurse anesthetists
  - Supervision by a surgeon of a CRNA

Coding Guidelines
Anesthesia codes describe the general anatomic area or service which relates to the surgical procedure. Only one anesthesia code should be reported unless the anesthesia code is an Add-on Code. Add-on Codes must be paired with a

primary procedure code in order to be eligible for reimbursement. All anesthesia services must be billed with the appropriate revenue code and CPT code. Claims that are submitted without the appropriate coding may be denied for incomplete coding and not be eligible for payment.

CPT Code	Description
00100-01860	Specify "Anesthesia for" followed by description of procedure
01916-01942	Anesthesia for radiological procedures
01952-01999	Anesthesia for burn excision/debridement, obstetrical procedures
99151-99157	Moderate (conscious) sedation services

CPT 01999: Unlisted anesthesia code CPT 01999 will require prior authorization. If a claim is submitted without an authorization on file, we will perform a retrospective -review.

CPT 99291 and CPT 99292: Critical care CPT codes are eligible for separate reimbursement when supported by the medical record according to all the requirements stipulated by the American Medical Association.

Anesthesia Claim Modifiers

Reimbursements will be made consistent with the provider's contract; in the absence of contract provisions the following reimbursement rates will be followed.

Modifier	Description	Who Can Bill	Reimbursement Percent of Allowed Amount
AA	Anesthesia services performed personally by anesthesiologist	Anesthesiologist MD	100%
AD	Medical supervision by an MD; more than four concurrent anesthesia procedures.	Anesthesiologist MD	50%
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals.	Anesthesiologist MD	50%
QY	Medical direction of one CRNA by an anesthesiologist	Anesthesiologist MD	50%
QZ	Anesthesia services performed by CRNA **without** medical direction by a physician	CRNA	100%
QX	Anesthesia services performed by CRNA **with** medical direction by a physician	CRNA	50%
GC	Anesthesia services performed by a resident under the direction of a teaching physician. Payment modifier must be used in conjunction.	Anesthesiologist MD	100%
QS	MAC services modifier is informational only. It can be used by MD or CRNA. Payment modifier must be used in conjunction.	N/A	N/A

Related Policies	
Related Training/ Job Aids	
NCQA Standard	
References	Medicare NCCI Coding Manual Anesthesia Services Medicare Claims Processing Manual Chapter 12
Exhibits	

Policy Owners / Reviewers			
Department Owner	Lisa Kuhls, Provider Relations Manager	**Date Reviewed**	
Department Reviewer	Network Strategy	**Date Reviewed**	
Approving Committee if applicable	☒Compliance ☐UMC ☐QIC ☐Board of Directors ☐Other: _____	**Date Approved**	
History			
Date of revision	*Summary of changes* Prior Reviews: Revised: Reviewed:		