Anesthesia

Reimbursement Policy ID: RPC.0028.0100

Recent review date: 05/2024

Next review date: 12/2024

Keystone First reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. Keystone First may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

Policy Overview

This policy addresses reimbursement of anesthesia services that are an integral part of procedural services.

Exceptions

This payment policy does not apply to CPT codes 01953 and 01996. According to the American Society of Anesthesiologists Relative Value Guide (ASA-RVG®), those codes are not reported as time-based services.

Reimbursement Guidelines

Anesthesia services must be submitted with at least one CPT anesthesia code in the range 00100-01999. These codes are reimbursed based on time units using the standard anesthesia formula.

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.

Required anesthesia modifiers	Provider type
AA	Anesthesiologist physician, personally performed

AD	Anesthesiologist physician, supervising over 4
QK	Anesthesiologist physician, supervising 2 — 4
QX	CRNA* or AA* directed by anesthesiologist physician
QY	Anesthesiologist physician, supervising 1
QZ	CRNA, personally performed

*CRNA = Certified Registered Nurse Anesthetist; AA = Anesthesiologist Assistant.

CRNA claims are directly payable to a CRNA when the member has Medicare as the primary insurance or if the member is age 21 or younger. CRNA claims are not reimbursable if the patient does not have Medicare or is not 21 years of age or younger. The explanation code will be **X51** - "***Service Not Covered***".

For members over the age of 21, CRNAs must bill under the supervising physician. Reimbursement will be 100% of the allowed amount when the QY or QX modifier is billed indicating the service was supervised. CRNA claims submitted with anesthesia codes and modifier QZ are not reimbursable. The QZ modifier indicates the service was not medically supervised.

Multiple procedure reduction
CPT codes 01967-01969 are excluded from multiple procedure reduction. All other codes are reimbursed at 100/0/0 percent except where 01967 and 01969 are reported together.

Physical status modifiers
CPT and American Society of Anesthesiologists guidelines identify six levels of ranking for patient physical status. These modifiers are informational only.

Physical status modifiers and description	Modifying units added to the Base Unit Value
P1— a normal healthy patient	0 units
P2 — a patient with mild systemic disease	0 units
P3 — a patient with moderate systemic disease	1 unit
P4 — a patient with 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 — A declared brain-dead patient whose organs are being removed for donor purposes	0 units

Informational modifiers
If reporting CPT modifier 23 or 47 or HCPCS modifier GC, G8, G9 or QS for anesthesia and pain management, then no additional reimbursement is allowed above the usual fee for the anesthesia service.

CPT modifier	CPT description	HCPCS modifier	HCPCS modifier description
23	Provider administered general anesthesia for a procedure that does not normally require it.	GC	Added to a CPT code for service(s) performed in part by a resident under the direction of a teaching physician
47	Anesthesia administered by the surgeon	G8	Monitored anesthesia care (MAC) for a deeply complex, complicated or markedly invasive surgical procedure

		G9	Monitored anesthesia care (MAC) for a patient who has history of severe cardiopulmonary condition
		QS	Monitored anesthesia care (MAC) services

Base values
Each CPT anesthesia code (00100-01999) is assigned a base value by the American Society of Anesthesiologists, and AmeriHealth Caritas Pennsylvania uses these values for determining reimbursement. The base value for each code is comprised of units referred to as the base unit value. For obstetrical anesthesia services (procedure codes 01960, 01961, 01962, 01963 and 01967), Pennsylvania Medicaid will use the same pricing formula but will adjust the base units by adding four units to the Medicare base units, to account for the particular manner in which these services are provided.

Time reporting
Consistent with PAMA and CMS guidelines, AmeriHealth Caritas Pennsylvania 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. Post-surgical pain blocks are frequently placed before anesthesia induction or after anesthesia emergence. When the pain block is placed before induction or after emergence, the time spent placing the pain block may not be added to the reported anesthesia time; this is true even if sedation and monitoring is provided to the member during pain block placement.

AmeriHealth Caritas Pennsylvania reimburses covered services based on the provider's contractual rates with the plan and the terms of reimbursement identified within this policy.

Definitions

N/A

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. Healthcare Common Procedure Coding System (HCPCS).
III. American Society of Anesthesiologists Relative Value Guide (ASA-RVG)
IV. Centers for Medicare and Medicaid Services (CMS), https://www.cms.gov/files/document/chapter2cptcodes00000-01999final11.pdf

Attachments

N/A

Associated Policies

N/A

Policy History

05/2024	Reimbursement Policy Committee Approval
04/2024	Revised preamble
08/2023	Removal of policy implemented by Keystone First from Policy History section

01/2023	Template revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines • Added Associated Policies section