Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP-033		
Subject:	Anesthesia Services		
Effective Date:	March 12, 2018	**End Date:**	
Issue Date:	December 1, 2025	**Revised Date:**	December 2025
Date Reviewed:	August 2025		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☐	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan.

REIMBURSEMENT GUIDELINES:

The following types of anesthesia qualify for reimbursement as anesthesia services:

1. Inhalation
2. Regional
    - Spinal (low spinal, saddle block)
    - Epidural (caudal)
    - Nerve block (retrobulbar, brachial plexus block, etc.)
    - Field block
3. Intravenous
4. Rectal
5. Conscious sedation

Anesthesia for diagnostic or therapeutic nerve blocks and injections (codes 01991 and 01992) are eligible for reimbursement when the block or injection is performed by a different provider. Local anesthesia (A9270), which is direct infiltration of the incision, wound, or lesion is not a covered service.

Reimbursement for anesthesia services is based on the use of relative value units, including base units, plus time units and eligible modifying units when appropriate, multiplied by a monetary conversion factor.

The basic value for anesthesia when multiple surgical procedures are performed is the basic value for the procedure with the highest unit value. Reimbursement is not allowed for the basic unit value of a second, third, etc., procedure.

Anesthesia time begins when the anesthesiologist or CRNA is first in attendance with the patient for the purpose of creating the anesthetic state. Anesthesia time ends when the anesthesiologist or CRNA is no longer in personal attendance; that is, when the patient may be safely placed under customary postoperative supervision. This time must be documented on the anesthesia record, but not on the claim.

Time must be indicated on all anesthesia claims. Report the actual time spent administering anesthesia as minutes on the claim in the "days or units" block. The Plan will convert total minutes to time units. A "time unit" is a measure of each fifteen (15) minute interval or the actual time reported. Time units are calculated by dividing the total minutes of anesthesia time reported by fifteen (15), rounding to one decimal place (e.g., total anesthesia time of 48 minutes divided by 15 equals 3.2 time units).

Note: Report units, not minutes for moderate (conscious) sedation.

Applicable codes: 01991 01992 A9270 J0670 J2001 J2795 S0020

Direction of Anesthesia Services

The amount for physician anesthesia services is based on allowable base and time units multiplied by an anesthesia conversion factor.

Concurrent directed anesthesia procedures are defined with regard to the maximum number of procedures that the physician is directing within the context of a single procedure.

Physicians must report the appropriate anesthesia modifier to denote whether the service was personally performed, directed, or supervised.

Specific anesthesia modifiers include:

Modifier	Definition
AA	Anesthesia services performed personally by the anesthesiologist
AD	Medical supervision by a physician; more than 4 concurrent anesthesia procedures
G8	Monitored anesthesia care (MAC) for deep complex complicated or markedly invasive surgical procedures
G9	Monitored anesthesia care for patient who has a history of severe cardio-pulmonary condition
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals
QS	Monitored anesthesia care service
QX	CRNA service; with medical direction by a physician
QY	Medical direction of one certified registered nurse anesthetist by an anesthesiologist
QZ	CRNA service: without medical direction by a physician

Note: The QS modifier is for informational purposes. Providers must report actual anesthesia time on the claim line.

Modifying Units for Anesthesia Services

The Plan does not separately reimburse for codes 99100, 99140, 99116 or 99135.

Monitoring Services Performed in Conjunction with the Administration of Anesthesia

The reporting of anesthesia services is appropriate by or under the responsible supervision of a physician. These services may include but are not limited to general, regional, supplementation of local anesthesia, or other supportive services to afford the patient the anesthesia care deemed optimal by the anesthesiologist during any procedure.

If monitoring services are reported on the same day as anesthesia, and the charges are itemized, the Plan will combine the charges and reimburse only the anesthesia. Reimbursement for the anesthesia performed on the same date of service includes the allowance for these services and are not eligible as a separate and distinct service. A participating or network provider cannot separately bill the member for these services. If these services are independently performed, report the service with modifier 59.

The Plan considers pre-operative and post-operative visits part of the global anesthesia allowance.

Examples of monitoring procedures performed during the course of administering anesthesia or for purposes of intraoperative anesthesia management are:

- ECG/EKG monitoring
- Administration of fluids and/or blood
- Respiratory functions (i.e., oxygen saturation [oximetry], end-tidal CO2 monitoring [capnography], etc.)
- Temperature
- Blood Pressure
- Mass spectrometry (Commercial products only)

Note: Modifier 59 may be reported with a non-E/M service, to identify it as distinct or independent from other non-E/M services performed on the same day. When modifier 59 is reported, the patient medical record must support its use in accordance with CPT guidelines.

Applicable Codes:

36430 36440 36450 36455 36460 83789 93000 93005 93010 93040 93041
93042 94680 94681 94690 94726 94727 94728 94729 94760 94761

Medicare Advantage Applicable Codes:

36430 36440 93000 93005 93010 93040 93041 93042 94680 94681 94690
94760 94761

Continuous Local Delivery of Analgesia to Operative Sites Using an Elastomeric Infusion Pump

Continuous infusion of an analgesic to operative wound sites is a technique for postoperative pain control for surgeries typically requiring oral or parenteral narcotics.

Local delivery of analgesia to operative sites is designed to reduce postoperative pain, while limiting systemic side effects of analgesia. Additional benefits include reduced need for oral narcotics, decreased

incidence of breakthrough pain, and faster return to normal activities. Drug delivery can be regulated through the use of simple disposable elastomeric pumps filled with analgesics attached to a variety of catheters that provide continuous delivery of the drug to the surgical site. Catheters may contain multiple openings so that the drug seeps into the operative wound all along its length. Elastomeric infusion pumps are designed to deliver drugs for up to five days followed by removal of the catheter. Elastomeric pumps to deliver local analgesia have been used postoperatively for the following:

- Orthopedic procedures, such as repair of the anterior cruciate ligament
- Urology procedures, such as prostatectomy
- Plastic surgery procedures
- Obstetrical/gynecologic procedures, such as cesarean section
- Gastrointestinal surgery procedures, such as hemorrhoidectomy or gastric bypass
- Thoracic surgery procedures, such as thoracotomy
- Cardiovascular surgery procedures, such as sternotomy

Only elastomeric pumps and associated catheters that have received approval from the US Food and Drug Administration (FDA) are to be used.

Reimbursement for catheter insertion and removal to provide continuous delivery of a drug to a surgical site is included in the allowance for the surgery and therefore, is not eligible for separate reimbursement.

The elastomeric infusion pump (codes A4305 and A4306) is a supply most commonly reported as a facility expense. However, when reported by the doctor, coverage for the elastomeric infusion pump is determined according to individual or group customer benefits.

Position Units

No allowance will be made for position. If extenuating circumstances exist in connection with the position of a patient, the services may be appealed for consideration by medical review.

Up to and including four (4) additional modifying units may be allowed when the anesthesiologist requests additional units for general anesthesia for congenital cataract extraction.

It will be necessary for the provider to submit medical records and/or additional documentation to determine coverage in this situation.

Anesthesia Services Prior to Postponement of Surgery

The Plan uses the following guidelines to adjudicate claims for the administration of anesthesia prior to the postponement of surgery:

1. If surgery is cancelled because of the anesthesiologist's preoperative appraisal, reimbursement can be made on the basis of a consultation. (Coverage for consultations is determined according to individual or group customer benefits.)
2. When surgery is aborted after general or regional anesthesia induction has taken place, reimbursement is made on the basis of 3 basic units plus time units multiplied by the conversion factor.
3. If anesthesia is reported under an NOC/NOS code, the Plan will adjudicate claims for the administration of anesthesia prior to the postponement of surgery, according to policy guidelines.

Payment for Personally Performed Anesthesia

Anesthesia payment is determined by the base unit for the anesthesia code and one time unit per 15 minutes of anesthesia time if:

1. The physician personally performed the entire anesthesia service alone, **or**;
2. The physician is a teaching physician involved with one or two concurrent resident cases or in one resident case that is concurrent to another case paid under medical direction payment rules (i.e., a nurse anesthetist or anesthesiologists' assistant case), **or**
3. The physician is continuously involved in a single case involving a student nurse anesthetist, **or**
4. If the physician is involved with a single case with a CRNA or an anesthesia assistant (AA), payment can be for the physician service and the CRNA (or AA) service in accordance with the medical direction payment policy, **or**
5. The physician and the CRNA (or AA) is involved in one anesthesia case and the services of each are found to be necessary. Documentation must be submitted by both the CRNA and the physician to support payment of the full fee for each of the two providers. The physician reports the "AA" modifier and the CRNA reports the "QZ" modifier for a non-necessary case.

Payment for Directed Anesthesia

Payment for the physician's directed service is determined on the basis of fifty (50) percent of the allowance for the service performed by the physician alone. Direction occurs if the physician directs qualified individuals in two, three, or four concurrent cases and the physician performs the following activities:

1. Performs a pre-anesthetic examination and evaluation;
2. Prescribes the anesthesia plan;
3. Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence;
4. Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist;
5. Monitors the course of anesthesia administration at frequent intervals;
6. Remains physically present and available for immediate diagnosis and treatment of emergencies; and
7. Provides indicated-post-anesthesia care.

The physician must participate only in the most demanding procedures of the anesthesia plan, including if applicable, induction and emergence. Also, for directed services, the physician must document in the medical record he or she performed the pre-anesthetic examination and evaluation. Physicians must also document they provided indicated post-anesthesia care, were present during some portion of the anesthesia monitoring, and were present during the most demanding procedures, including induction and emergence, where indicated.

The physician can direct two, three, or four concurrent procedures involving qualified individuals, all of whom could be CRNAs, AAs, interns, residents, or combinations of these individuals. The direction rules apply to cases involving student nurse anesthetists if the physician directs two concurrent cases, each of which involves a student nurse anesthetist, or the physician directs one case involving a student nurse anesthetist and another involving a CRNA, AA, intern, or resident. The reimbursement amount for the physician service and the qualified individual service is fifty (50) percent (for each service) of the allowance otherwise recognized had the service been furnished solely by the anesthesiologist. Modifier QK or QY should be appended to the procedure code(s) in these cases.

A physician who is concurrently directing the administration of anesthesia to not more than four surgical patients cannot ordinarily be involved in performing additional services to other patients. However, addressing an emergency of short duration in the immediate area, administering an epidural or caudal anesthetic to ease labor pain, or periodic, rather than continuous, monitoring of an obstetrical patient does not substantially diminish the scope of control exercised by the physician in directing the administration of anesthesia to surgical patients. It does not constitute a separate service for the purpose of determining whether the direction criteria are met. Further, while directing concurrent anesthesia procedures, a physician may receive patients entering the operating suite for the next surgery, check or discharge patients in the recovery room, or handle scheduling matters without affecting fee schedule payment.

However, if the physician leaves the immediate area of the operating suite for other than short durations or devotes extensive time to an emergency case or is otherwise not available to respond to the immediate needs of the surgical patients, the physician's services to the surgical patients are supervisory in nature and reimbursement cannot be made.

Only three base units per procedure may be allowed when the anesthesiologist is involved in performing more than four procedures concurrently or is performing other services while directing the concurrent procedures. An additional time unit may be recognized if the physician can document that they were personally present at induction.

If anesthesiologists are in a group practice, one physician member may provide the pre-anesthesia examination and evaluation while another fulfills the other criteria. Similarly, one physician member of the group may provide post-anesthesia care while another member of the group performs the other component parts of the anesthesia service. However, the patient medical record must indicate the services were performed by physicians and identify the physicians who performed them.

Anesthesia Services Provided by a Qualified Anesthetist

Reimbursement will be made for directed services when only one service is supervised. The payment amount for the physician service and the CRNA service is fifty (50) percent (for each service) of the allowance otherwise recognized had the service been furnished solely by the anesthesiologist. Modifier QX should be appended to the procedure code(s) in these cases.

Note: This section is not applicable to the West Virginia Region

Screening Colonoscopy

Anesthesia services performed in support of a screening colonoscopy are reported with code 00812. When a screening colonoscopy becomes a diagnostic colonoscopy, anesthesia services are reported with code 00811 with the PT modifier appended to the claim line.

Dental Anesthesia

The Plan uses the following guidelines from the American Dental Association (ADA) for reporting dental anesthesia services. For the initial 15 minutes of anesthesia services provided using the appropriate Common Dental Terminology (CDT) Code:

D9222 – for deep sedation/general anesthesia, initial 15 minutes.

D9239 – for intravenous moderate (conscious) sedation/analgesia, initial 15 minutes.

Note: Base unit values will apply only to the initial 15 mins of service. Submit as one unit.

Submit subsequent 15-minute increments of anesthesia services provided (after the initial 15 minutes) using the appropriate CDT code:

D9223 – for deep sedation/general anesthesia, each subsequent 15-minute increment

D9243 – for intravenous moderate (conscience) sedation/analgesia, each subsequent 15-minute increment.

Note: Please bill one unit for every 15 minutes of anesthesia time on a separate claim line.

Labor and Delivery *(Commercial Only)*

Anesthesia for Obstetrics services would focus on management of pregnant patients during labor, non-operative delivery, operative delivery, and selected aspects of postpartum care.

Commercial Applicable Codes:

01958	01960	01961	01962	01963	01965	01966	01967	01968	01969
62273	62281	62282							

Add-on codes are always performed in addition to the primary service or procedure and must never be reported as a standalone code on a separate claim. In situations where obstetrical anesthesia for planned vaginal delivery begins on one day and ends in caesarean delivery on the following day, the date of service for both codes (01967 and 01968) should be the date of delivery. Codes should not be reported on separate claims or span multiple dates of service. Add-on codes submitted with no primary code or a different date of service result in rejection and non-payment of the add-on code.

Epidural Anesthesia Care *(Commercial Only)*

When epidural anesthesia care is provided either 1) during labor only, or 2) during labor and vaginal delivery, code 01967 should be reported. The total time reported should reflect actual time in personal attendance (i.e., “face time”) with the patient. Payment for code 01967 will be based on the appropriate number of base units (BU) and total time units (TU) in attendance with the patient either during labor only or during labor with vaginal delivery.

When procedure code 01967 is reported in conjunction with either 01968 or 01969, the base units and time units for each code should be reimbursed. Time units reported should reflect actual time in personal attendance (“face time”) with the patient. The appropriate anesthesia modifier should be reported with each code to determine the level of reimbursement for each code, i.e., 100 percent or 50 percent, as in the following examples:

Example 1 The anesthesiologist personally performs the labor epidural and the cesarean section:

Line 1 01967 - AA BU + TU x conversion factor = 100%
Line 2 01968 - AA BU + TU x conversion factor = 100%

Example 2 The anesthesiologist personally performs the labor epidural and medically directs a CRNA (non-employee) during the cesarean section.

Line 1 01967 - AA BU + TU x conversion factor = 100%
Line 2 01968 - QK BU + TU x conversion factor x 50% = 50%

Note: Procedure codes 01960, 01961, and 01962 should not be reported in conjunction with 01967.

Daily management of epidural drug administration (01996) is also eligible for separate payment after the day on which an epidural catheter is inserted. Daily management reported on the same day as the catheter insertion is not covered. A participating, preferred, or network provider cannot bill the member for daily management on the same day as the catheter insertion.

Physical Status Units *(Commercial Only)*

Patient physical status should be reported under the appropriate modifier (P1 - P6).

Physical Status I (Modifier P1): *Units allowed = 0*

- This modifier represents a normally healthy patient. There is no organic, physiologic, biochemical, or psychiatric disturbance. The pathological process for which the operation is to be performed is localized and not conducive to systemic disturbance.

Physical Status II (Modifier P2): Units allowed = 0

- This modifier represents a patient with mild to moderate systemic disturbance caused either by the condition to be treated surgically or by other pathophysiologic processes.

Physical Status III (Modifier P3): *Units allowed = 1*

- This modifier represents a patient with severe systemic disease.

Physical Status IV (Modifier P4): Units allowed = 2

- This modifier represents a patient with severe systemic disorder already life threatening and not always correctable by operative procedures.

Physical Status V (Modifier P5): Units allowed = 3

- This modifier represents a moribund patient who has little chance of survival but is submitted to operation in desperation. This classification is rarely used.

Physical Status VI (Modifier P6): *Units allowed = 0*

DEFINITIONS:

Modifier	Definition
59	Distinct procedural service
PT	Colorectal cancer screening test; converted to diagnostic test or other procedure

RELATED POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-009: Modifiers 25, 59, XE, XP, XS and XU
- RP-025: Implantation of Subcutaneous Intravascular Catheter

- RP-035: Correct Coding Guidelines
- RP-041: Services not Separately Reimbursed

REFERENCES:

- CMS Online Manual Publication: 100-04, Chapter 12, Section 50
- Current Procedural Terminology (CPT)
- National Uniform Billing committee

POLICY UPDATE HISTORY INFORMATION:

3 / 2018	Implementation
8 / 2019	Added Dental, Labor and Delivery
10 / 2019	Added additional verbiage related to Dental, Labor and Delivery
10 / 2021	Added NY region applicable to the policy with note for NY under Modifying Units section
12 / 2021	Added the plan will not separately reimburse for codes 99100, 99116, 99135, 99140
6 / 2022	Removed CPT 94770, 94750. Removed MA Medical Policy N-118
10 / 2022	Removed MP N-118 verbiage from page 6
2 / 2024	Administrative policy review with no changes in policy direction
4 / 2025	Clarified section for Screening Colonoscopy code 00812
12 / 2025	Added 62273, 62281, 62282, 01967-01969. Added Epidural Anesthesia Care section. Clarified direction for modifiers QK and QY.

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-033		
Subject:	Anesthesia Services		
Effective Date:	March 12, 2018	**End Date:**	
Issue Date:	April 28, 2025	**Revised Date:**	April 2025
Date Reviewed:	April 2025		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Claim Type	**UB**	☐	**1500**	☒			

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

This policy is to provide direction on the Plan's reimbursement of anesthesia services.

REIMBURSEMENT GUIDELINES:

The following types of anesthesia qualify for reimbursement as anesthesia services:

1. Inhalation
2. Regional
    - Spinal (low spinal, saddle block)
    - Epidural (caudal)
    - Nerve block (retrobulbar, brachial plexus block, etc.)
    - Field block
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The basic value for anesthesia when multiple surgical procedures are performed is the basic value for the procedure with the highest unit value. Reimbursement is not allowed for the basic unit value of a second, third, etc., procedure.

Anesthesia time begins when the anesthesiologist or CRNA is first in attendance with the patient for the purpose of creating the anesthetic state. Anesthesia time ends when the anesthesiologist or CRNA is no longer in personal attendance; that is, when the patient may be safely placed under customary postoperative supervision. This time must be documented on the anesthesia record, but not on the claim.

Time must be indicated on all anesthesia claims. Report the actual time spent administering anesthesia as minutes on the claim in the "days or units" block. The Plan will convert total minutes to time units. A "time unit" is a measure of each fifteen (15) minute interval or the actual time reported. Time units are calculated by dividing the total minutes of anesthesia time reported by fifteen (15), rounding to one decimal place (e.g., total anesthesia time of 48 minutes divided by 15 equals 3.2 time units).

Note: Report units, not minutes for moderate (conscious) sedation.

Applicable codes: 01991 01992 A9270 J0670 J2001 J2795 S0020

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Specific anesthesia modifiers include:

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QY	Medical direction of one certified registered nurse anesthetist by an anesthesiologist
QZ	CRNA service: without medical direction by a physician

Note: The QS modifier is for informational purposes. Providers must report actual anesthesia time on the claim.

Modifying Units for Anesthesia Services

The Plan does not separately reimburse for the following codes 99100, 99140, 99116 or 99135.

Monitoring Services Performed in Conjunction with the Administration of Anesthesia

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If monitoring services are reported on the same day as anesthesia, and the charges are itemized, the Plan will combine the charges and reimburse only the anesthesia. Reimbursement for the anesthesia performed on the same date of service includes the allowance for these services and are not eligible as a separate and distinct service. A participating or network provider cannot separately bill the member for these services. If these services are independently performed, report the service with modifier 59.

The Plan considers pre-operative and post-operative visits part of the global anesthesia allowance.

Examples of monitoring procedures performed during the course of administering anesthesia or for purposes of intraoperative anesthesia management are:

- ECG/EKG monitoring
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- Respiratory functions (i.e., oxygen saturation [oximetry], end-tidal CO2 monitoring [capnography], etc.)
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Note: Modifier 59 may be reported with a non-E/M service, to identify it as distinct or independent from other non-E/M services performed on the same day. When modifier 59 is reported, the patient medical record must support its use in accordance with CPT guidelines.

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- Orthopedic procedures, such as repair of the anterior cruciate ligament
- Urology procedures, such as prostatectomy
- Plastic surgery procedures
- Obstetrical/gynecologic procedures, such as cesarean section
- Gastrointestinal surgery procedures, such as hemorrhoidectomy or gastric bypass
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Only elastomeric pumps and associated catheters that have received approval from the US Food and Drug Administration (FDA) are to be used.

Reimbursement for catheter insertion and removal to provide continuous delivery of a drug to a surgical site is included in the allowance for the surgery and therefore, is not eligible for separate reimbursement.

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2. When surgery is aborted after general or regional anesthesia induction has taken place, reimbursement is made on the basis of 3 basic units plus time units multiplied by the conversion factor.
3. If anesthesia is reported under an NOC/NOS code, the Plan will adjudicate claims for the administration of anesthesia prior to the postponement of surgery, according to policy guidelines.

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3. The physician is continuously involved in a single case involving a student nurse anesthetist, **or**
4. If the physician is involved with a single case with a CRNA or an anesthesia assistant (AA), payment can be for the physician service and the CRNA (or AA) service in accordance with the medical direction payment policy, **or**
5. The physician and the CRNA (or AA) is involved in one anesthesia case and the services of each are found to be necessary. Documentation must be submitted by both the CRNA and the physician to support payment of the full fee for each of the two providers. The physician reports the "AA" modifier and the CRNA reports the "QZ" modifier for a non-necessary case.

Payment for Directed Anesthesia

Payment for the physician's directed service is determined on the basis of fifty (50) percent of the allowance for the service performed by the physician alone. Direction occurs if the physician directs qualified individuals in two, three, or four concurrent cases and the physician performs the following activities:

1. Performs a pre-anesthetic examination and evaluation;
2. Prescribes the anesthesia plan;
3. Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence;
4. Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist;
5. Monitors the course of anesthesia administration at frequent intervals;
6. Remains physically present and available for immediate diagnosis and treatment of emergencies; and
7. Provides indicated-post-anesthesia care.

The physician must participate only in the most demanding procedures of the anesthesia plan, including if applicable, induction and emergence. Also, for directed services, the physician must document in the medical record he or she performed the pre-anesthetic examination and evaluation. Physicians must also document they provided indicated post-anesthesia care, were present during some portion of the anesthesia monitoring, and were present during the most demanding procedures, including induction and emergence, where indicated.

The physician can direct two, three, or four concurrent procedures involving qualified individuals, all of whom could be CRNAs, AAs, interns, residents, or combinations of these individuals. The direction rules

apply to cases involving student nurse anesthetists if the physician directs two concurrent cases, each of which involves a student nurse anesthetist, or the physician directs one case involving a student nurse anesthetist and another involving a CRNA, AA, intern, or resident.

A physician who is concurrently directing the administration of anesthesia to not more than four surgical patients cannot ordinarily be involved in performing additional services to other patients. However, addressing an emergency of short duration in the immediate area, administering an epidural or caudal anesthetic to ease labor pain, or periodic, rather than continuous, monitoring of an obstetrical patient does not substantially diminish the scope of control exercised by the physician in directing the administration of anesthesia to surgical patients. It does not constitute a separate service for the purpose of determining whether the direction criteria are met. Further, while directing concurrent anesthesia procedures, a physician may receive patients entering the operating suite for the next surgery, check or discharge patients in the recovery room, or handle scheduling matters without affecting fee schedule payment.

However, if the physician leaves the immediate area of the operating suite for other than short durations or devotes extensive time to an emergency case or is otherwise not available to respond to the immediate needs of the surgical patients, the physician's services to the surgical patients are supervisory in nature and reimbursement cannot be made.

Only three base units per procedure may be allowed when the anesthesiologist is involved in performing more than four procedures concurrently or is performing other services while directing the concurrent procedures. An additional time unit may be recognized if the physician can document that they were personally present at induction.

If anesthesiologists are in a group practice, one physician member may provide the pre-anesthesia examination and evaluation while another fulfills the other criteria. Similarly, one physician member of the group may provide post-anesthesia care while another member of the group performs the other component parts of the anesthesia service. However, the patient medical record must indicate the services were performed by physicians and identify the physicians who performed them.

Anesthesia Services Provided by a Qualified Anesthetist

Reimbursement will be made for directed services when only one service is supervised. The payment amount for the physician service and the CRNA service is fifty (50) percent (for each service) of the allowance otherwise recognized had the service been furnished solely by the anesthesiologist. Modifier QX should be appended to the procedure code(s) in these cases.

Note: This section is not applicable to the West Virginia Region

Screening Colonoscopy

Anesthesia services performed in support of a screening colonoscopy are reported with code 00812. When a screening colonoscopy becomes a diagnostic colonoscopy, anesthesia services are reported with code 00811 with the PT modifier appended to the claim line.

Dental Anesthesia

The Plan uses the following guidelines from the American Dental Association (ADA) for reporting dental anesthesia services. For the initial 15 minutes of anesthesia services provided using the appropriate Common Dental Terminology (CDT) Code:

D9222 – for deep sedation/general anesthesia, initial 15 minutes.

D9239 – for intravenous moderate (conscious) sedation/analgesia, initial 15 minutes.

Note: Base unit values will apply only to the initial 15 mins of service. Submit as one unit.

Submit subsequent 15-minute increments of anesthesia services provided (after the initial 15 minutes) using the appropriate CDT code:

D9223 – for deep sedation/general anesthesia, each subsequent 15-minute increment

D9243 – for intravenous moderate (conscience) sedation/analgesia, each subsequent 15-minute increment.

Note: Please bill one unit for every 15 minutes of anesthesia time on a separate claim line.

Labor and Delivery *(Commercial Only)*

Anesthesia for Obstetrics services would focus on management of pregnant patients during labor, non-operative delivery, operative delivery, and selected aspects of postpartum care.

Commercial Applicable Codes:

01958 01960 01961 01962 01963 01965 01966 01967 01968 01969

Add-on codes are always performed in addition to the primary service or procedure and must never be reported as a standalone code on a separate claim. In situations where obstetrical anesthesia for planned vaginal delivery begins on one day and ends in caesarean delivery on the following day, the date of service for both codes (01967 and 01968) should be the date of delivery. Codes should not be reported on separate claims or span multiple dates of service. Add-on codes submitted with no primary code or a different date of service result in rejection and non-payment of the add-on code.

Physical Status Units *(Commercial Only)*

Patient physical status should be reported under the appropriate modifier (P1 - P6).

Physical Status I (Modifier P1): Units allowed = 0

- This modifier represents a normally healthy patient. There is no organic, physiologic, biochemical, or psychiatric disturbance. The pathological process for which the operation is to be performed is localized and not conducive to systemic disturbance.

Physical Status II (Modifier P2): Units allowed = 0

- This modifier represents a patient with mild to moderate systemic disturbance caused either by the condition to be treated surgically or by other pathophysiologic processes.

Physical Status III (Modifier P3): Units allowed = 1

- This modifier represents a patient with severe systemic disease.

Physical Status IV (Modifier P4): Units allowed = 2

- This modifier represents a patient with severe systemic disorder already life threatening and not always correctable by operative procedures.

Physical Status V (Modifier P5): Units allowed = 3

- This modifier represents a moribund patient who has little chance of survival but is submitted to operation in desperation. This classification is rarely used.

Physical Status VI (Modifier P6): Units allowed = 0

DEFINITIONS:

Modifier	Definition
59	Distinct procedural service
PT	Colorectal cancer screening test; converted to diagnostic test or other procedure

RELATED POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-025: Implantation of Subcutaneous Intravascular Catheter
- RP-009: Modifiers 25, 59, XE, XP, XS and XU
- RP-035: Correct Coding Guidelines
- RP-041: Services not Separately Reimbursed

REFERENCES:

- CMS Online Manual Publication: 100-04, Chapter 12, Section 50
- Current Procedural Terminology (CPT)
- National Uniform Billing committee

POLICY UPDATE HISTORY INFORMATION:

3 / 2018	Implementation
8 / 2019	Added Dental, Labor and Delivery
10 / 2019	Added additional verbiage related to Dental, Labor and Delivery
10 / 2021	Added NY region applicable to the policy with note for NY under Modifying Units section
12 / 2021	Added the plan will not separately reimburse for codes 99100, 99116, 99135, 99140
6 / 2022	Removed CPT 94770, 94750. Removed MA Medical Policy N-118
10 / 2022	Removed MP N-118 verbiage from page 6
2 / 2024	Administrative policy review with no changes in policy direction
4 / 2025	Clarified section for Screening Colonoscopy code 00812

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-033		
Subject:	Anesthesia Services		
Effective Date:	March 12, 2018	**End Date:**	
Issue Date:	February 5, 2024	**Revised Date:**	February 2024
Date Reviewed:	January 2024		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Claim Type	**UB**	☐	**1500**	☒			

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

This policy is to provide direction on the Plan's reimbursement of anesthesia services.

REIMBURSEMENT GUIDELINES:

The following types of anesthesia qualify for reimbursement as anesthesia services:

1. Inhalation
2. Regional
    - Spinal (low spinal, saddle block)
    - Epidural (caudal)
    - Nerve block (retrobulbar, brachial plexus block, etc.)
    - Field block
3. Intravenous
4. Rectal
5. Conscious sedation

Anesthesia for diagnostic or therapeutic nerve blocks and injections (codes 01991 and 01992) are eligible for reimbursement when the block or injection is performed by a different provider. Local anesthesia (A9270), which is direct infiltration of the incision, wound, or lesion is not a covered service.

Reimbursement for anesthesia services is based on the use of relative value units, including base units, plus time units and eligible modifying units when appropriate, multiplied by a monetary conversion factor.

The basic value for anesthesia when multiple surgical procedures are performed is the basic value for the procedure with the highest unit value. Reimbursement is not allowed for the basic unit value of a second, third, etc., procedure.

Anesthesia time begins when the anesthesiologist or CRNA is first in attendance with the patient for the purpose of creating the anesthetic state. Anesthesia time ends when the anesthesiologist or CRNA is no longer in personal attendance; that is, when the patient may be safely placed under customary postoperative supervision. This time must be documented on the anesthesia record, but not on the claim.

Time must be indicated on all anesthesia claims. Report the actual time spent administering anesthesia as minutes on the claim in the "days or units" block. The Plan will convert total minutes to time units. A "time unit" is a measure of each fifteen (15) minute interval or the actual time reported. Time units are calculated by dividing the total minutes of anesthesia time reported by fifteen (15), rounding to one decimal place (e.g., total anesthesia time of 48 minutes divided by 15 equals 3.2 time units).

Note: Report units, not minutes for moderate (conscious) sedation.

Applicable codes: 01991 01992 A9270 J0670 J2001 J2795 S0020

Direction of Anesthesia Services

The amount for physician anesthesia services is based on allowable base and time units multiplied by an anesthesia conversion factor.

Concurrent directed anesthesia procedures are defined with regard to the maximum number of procedures that the physician is directing within the context of a single procedure.

Physicians must report the appropriate anesthesia modifier to denote whether the service was personally performed, directed, or supervised.

Specific anesthesia modifiers include:

Modifier	Definition
AA	Anesthesia services performed personally by the anesthesiologist
AD	Medical supervision by a physician; more than 4 concurrent anesthesia procedures
G8	Monitored anesthesia care (MAC) for deep complex complicated or markedly invasive surgical procedures
G9	Monitored anesthesia care for patient who has a history of severe cardio-pulmonary condition
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals
QS	Monitored anesthesia care service
QX	CRNA service; with medical direction by a physician

QY	Medical direction of one certified registered nurse anesthetist by an anesthesiologist
QZ	CRNA service: without medical direction by a physician

Note: The QS modifier is for informational purposes. Providers must report actual anesthesia time on the claim.

Modifying Units for Anesthesia Services

The Plan does not separately reimburse for the following codes 99100, 99140, 99116 or 99135.

Monitoring Services Performed in Conjunction with the Administration of Anesthesia

The reporting of anesthesia services is appropriate by or under the responsible supervision of a physician. These services may include but are not limited to general, regional, supplementation of local anesthesia, or other supportive services to afford the patient the anesthesia care deemed optimal by the anesthesiologist during any procedure.

If monitoring services are reported on the same day as anesthesia, and the charges are itemized, the Plan will combine the charges and reimburse only the anesthesia. Reimbursement for the anesthesia performed on the same date of service includes the allowance for these services and are not eligible as a separate and distinct service. A participating or network provider cannot separately bill the member for these services. If these services are independently performed, report the service with modifier 59.

The Plan considers pre-operative and post-operative visits part of the global anesthesia allowance.

Examples of monitoring procedures performed during the course of administering anesthesia or for purposes of intraoperative anesthesia management are:

- ECG/EKG monitoring
- Administration of fluids and/or blood
- Respiratory functions (i.e., oxygen saturation [oximetry], end-tidal CO2 monitoring [capnography], etc.)
- Temperature
- Blood Pressure
- Mass spectrometry (Commercial products only)

Note: Modifier 59 may be reported with a non-E/M service, to identify it as distinct or independent from other non-E/M services performed on the same day. When modifier 59 is reported, the patient medical record must support its use in accordance with CPT guidelines.

Applicable Codes:

36430 36440 36450 36455 36460 83789 93000 93005 93010 93040 93041
93042 94680 94681 94690 94726 94727 94728 94729 94760 94761

Medicare Advantage Applicable Codes:

36430 36440 93000 93005 93010 93040 93041 93042 94680 94681 94690
94760 94761

Continuous Local Delivery of Analgesia to Operative Sites Using an Elastomeric Infusion Pump

Continuous infusion of an analgesic to operative wound sites is a technique for postoperative pain control for surgeries typically requiring oral or parenteral narcotics.

Local delivery of analgesia to operative sites is designed to reduce postoperative pain, while limiting systemic side effects of analgesia. Additional benefits include reduced need for oral narcotics, decreased incidence of breakthrough pain, and faster return to normal activities. Drug delivery can be regulated through the use of simple disposable elastomeric pumps filled with analgesics attached to a variety of catheters that provide continuous delivery of the drug to the surgical site. Catheters may contain multiple openings so that the drug seeps into the operative wound all along its length. Elastomeric infusion pumps are designed to deliver drugs for up to five days followed by removal of the catheter. Elastomeric pumps to deliver local analgesia have been used postoperatively for the following:

- Orthopedic procedures, such as repair of the anterior cruciate ligament
- Urology procedures, such as prostatectomy
- Plastic surgery procedures
- Obstetrical/gynecologic procedures, such as cesarean section
- Gastrointestinal surgery procedures, such as hemorrhoidectomy or gastric bypass
- Thoracic surgery procedures, such as thoracotomy
- Cardiovascular surgery procedures, such as sternotomy

Only elastomeric pumps and associated catheters that have received approval from the US Food and Drug Administration (FDA) are to be used.

Reimbursement for catheter insertion and removal to provide continuous delivery of a drug to a surgical site is included in the allowance for the surgery and therefore, is not eligible for separate reimbursement.

The elastomeric infusion pump (codes A4305 and A4306) is a supply most commonly reported as a facility expense. However, when reported by the doctor, coverage for the elastomeric infusion pump is determined according to individual or group customer benefits.

Position Units

No allowance will be made for position. If extenuating circumstances exist in connection with the position of a patient, the services may be appealed for consideration by medical review.

Up to and including four (4) additional modifying units may be allowed when the anesthesiologist requests additional units for general anesthesia for congenital cataract extraction.

It will be necessary for the provider to submit medical records and/or additional documentation to determine coverage in this situation.

Anesthesia Services Prior to Postponement of Surgery

The Plan uses the following guidelines to adjudicate claims for the administration of anesthesia prior to the postponement of surgery:

1. If surgery is cancelled because of the anesthesiologist's preoperative appraisal, reimbursement can be made on the basis of a consultation. (Coverage for consultations is determined according to individual or group customer benefits.)

2. When surgery is aborted after general or regional anesthesia induction has taken place, reimbursement is made on the basis of 3 basic units plus time units multiplied by the conversion factor.
3. If anesthesia is reported under an NOC/NOS code, the Plan will adjudicate claims for the administration of anesthesia prior to the postponement of surgery, according to policy guidelines.

Payment for Personally Performed Anesthesia

Anesthesia payment is determined by the base unit for the anesthesia code and one time unit per 15 minutes of anesthesia time if:

1. The physician personally performed the entire anesthesia service alone, **or**;
2. The physician is a teaching physician involved with one or two concurrent resident cases or in one resident case that is concurrent to another case paid under medical direction payment rules (i.e., a nurse anesthetist or anesthesiologists' assistant case), **or**
3. The physician is continuously involved in a single case involving a student nurse anesthetist, **or**
4. If the physician is involved with a single case with a CRNA or an anesthesia assistant (AA), payment can be for the physician service and the CRNA (or AA) service in accordance with the medical direction payment policy, **or**
5. The physician and the CRNA (or AA) is involved in one anesthesia case and the services of each are found to be necessary. Documentation must be submitted by both the CRNA and the physician to support payment of the full fee for each of the two providers. The physician reports the "AA" modifier and the CRNA reports the "QZ" modifier for a non-necessary case.

Payment for Directed Anesthesia

Payment for the physician's directed service is determined on the basis of fifty (50) percent of the allowance for the service performed by the physician alone. Direction occurs if the physician directs qualified individuals in two, three, or four concurrent cases and the physician performs the following activities:

1. Performs a pre-anesthetic examination and evaluation;
2. Prescribes the anesthesia plan;
3. Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence;
4. Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist;
5. Monitors the course of anesthesia administration at frequent intervals;
6. Remains physically present and available for immediate diagnosis and treatment of emergencies; and
7. Provides indicated-post-anesthesia care.

The physician must participate only in the most demanding procedures of the anesthesia plan, including if applicable, induction and emergence. Also, for directed services, the physician must document in the medical record he or she performed the pre-anesthetic examination and evaluation. Physicians must also document they provided indicated post-anesthesia care, were present during some portion of the anesthesia monitoring, and were present during the most demanding procedures, including induction and emergence, where indicated.

The physician can direct two, three, or four concurrent procedures involving qualified individuals, all of whom could be CRNAs, AAs, interns, residents, or combinations of these individuals. The direction rules

apply to cases involving student nurse anesthetists if the physician directs two concurrent cases, each of which involves a student nurse anesthetist, or the physician directs one case involving a student nurse anesthetist and another involving a CRNA, AA, intern, or resident.

A physician who is concurrently directing the administration of anesthesia to not more than four surgical patients cannot ordinarily be involved in performing additional services to other patients. However, addressing an emergency of short duration in the immediate area, administering an epidural or caudal anesthetic to ease labor pain, or periodic, rather than continuous, monitoring of an obstetrical patient does not substantially diminish the scope of control exercised by the physician in directing the administration of anesthesia to surgical patients. It does not constitute a separate service for the purpose of determining whether the direction criteria are met. Further, while directing concurrent anesthesia procedures, a physician may receive patients entering the operating suite for the next surgery, check or discharge patients in the recovery room, or handle scheduling matters without affecting fee schedule payment.

However, if the physician leaves the immediate area of the operating suite for other than short durations or devotes extensive time to an emergency case or is otherwise not available to respond to the immediate needs of the surgical patients, the physician's services to the surgical patients are supervisory in nature and reimbursement cannot be made.

Only three base units per procedure may be allowed when the anesthesiologist is involved in performing more than four procedures concurrently or is performing other services while directing the concurrent procedures. An additional time unit may be recognized if the physician can document that they were personally present at induction.

If anesthesiologists are in a group practice, one physician member may provide the pre-anesthesia examination and evaluation while another fulfills the other criteria. Similarly, one physician member of the group may provide post-anesthesia care while another member of the group performs the other component parts of the anesthesia service. However, the patient medical record must indicate the services were performed by physicians and identify the physicians who performed them.

Anesthesia Services Provided by a Qualified Anesthetist

Reimbursement will be made for directed services when only one service is supervised. The payment amount for the physician service and the CRNA service is fifty (50) percent (for each service) of the allowance otherwise recognized had the service been furnished solely by the anesthesiologist. Modifier QX should be appended to the procedure code(s) in these cases.

Note: This section is not applicable to the West Virginia Region

Screening Colonoscopy

When a screening colonoscopy becomes a diagnostic colonoscopy, anesthesia services are reported with CPT code 00811 (Anesthesia for lower intestinal endoscopic procedures, endoscopy introduced distal to duodenum; not otherwise specified) and with the PT modifier.

Dental Anesthesia

The Plan uses the following guidelines from the American Dental Association (ADA) for reporting dental anesthesia services. For the initial 15 minutes of anesthesia services provided using the appropriate Common Dental Terminology (CDT) Code:

D9222 – for deep sedation/general anesthesia, initial 15 minutes.

D9239 – for intravenous moderate (conscious) sedation/analgesia, initial 15 minutes.

Note: Base unit values will apply only to the initial 15 mins of service. Submit as one unit.

Submit subsequent 15-minute increments of anesthesia services provided (after the initial 15 minutes) using the appropriate CDT code:

D9223 – for deep sedation/general anesthesia, each subsequent 15-minute increment

D9243 – for intravenous moderate (conscience) sedation/analgesia, each subsequent 15-minute increment.

Note: Please bill one unit for every 15 minutes of anesthesia time on a separate claim line.

Labor and Delivery *(Commercial Only)*

Anesthesia for Obstetrics services would focus on management of pregnant patients during labor, non-operative delivery, operative delivery, and selected aspects of postpartum care.

Commercial Applicable Codes:

01958 01960 01961 01962 01963 01965 01966 01967 01968 01969

Add-on codes are always performed in addition to the primary service or procedure and must never be reported as a standalone code on a separate claim. In situations where obstetrical anesthesia for planned vaginal delivery begins on one day and ends in caesarean delivery on the following day, the date of service for both codes (01967 and 01968) should be the date of delivery. Codes should not be reported on separate claims or span multiple dates of service. Add-on codes submitted with no primary code or a different date of service result in rejection and non-payment of the add-on code.

Physical Status Units *(Commercial Only)*

Patient physical status should be reported under the appropriate modifier (P1-P6).

Physical Status I (Modifier P1): *Units allowed = 0*

- This modifier represents a normally healthy patient. There is no organic, physiologic, biochemical, or psychiatric disturbance. The pathological process for which the operation is to be performed is localized and not conducive to systemic disturbance.

Physical Status II (Modifier P2): Units allowed = 0

- This modifier represents a patient with mild to moderate systemic disturbance caused either by the condition to be treated surgically or by other pathophysiologic processes.

Physical Status III (Modifier P3): *Units allowed = 1*

- This modifier represents a patient with severe systemic disease.

Physical Status IV (Modifier P4): Units allowed = 2

- This modifier represents a patient with severe systemic disorder already life threatening and not always correctable by operative procedures.

Physical Status V (Modifier P5): Units allowed = 3

- This modifier represents a moribund patient who has little chance of survival but is submitted to operation in desperation. This classification is rarely used.

Physical Status VI (Modifier P6): Units allowed = 0

DEFINITIONS:

Modifier	Definition
59	Distinct procedural service
PT	Colorectal cancer screening test; converted to diagnostic test or other procedure

RELATED POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-025: Implantation of Subcutaneous Intravascular Catheter
- RP-009: Modifiers 25, 59, XE, XP, XS and XU
- RP-041: Services not Separately Reimbursed

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

- Provider Communication issued November 20, 2018.

REFERENCES:

- CMS Online Manual Publication: 100-04, Chapter 12, Section 50
- Current Procedural Terminology (CPT)
- National Uniform Billing committee

POLICY UPDATE HISTORY INFORMATION:

3 / 2018	Implementation
8 / 2019	Added Dental, Labor and Delivery
10 / 2019	Added additional verbiage related to Dental, Labor and Delivery
10 / 2021	Added NY region applicable to the policy with note for NY under Modifying Units section
12 / 2021	Added the plan will not separately reimburse for codes 99100, 99116, 99135, 99140
6 / 2022	Removed CPT 94770, 94750. Removed MA Medical Policy N-118
10 / 2022	Removed MP N-118 verbiage from page 6
2 / 2024	Administrative policy review with no changes in policy direction

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-033		
Subject:	Anesthesia Services		
Effective Date:	March 12, 2018	**End Date:**	
Issue Date:	October 17, 2022	**Revised Date:**	October 2022
Date Reviewed:	October 2022		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☐	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

This policy is to provide direction on the Plan's reimbursement of anesthesia services.

REIMBURSEMENT GUIDELINES:

The following types of anesthesia qualify for reimbursement as anesthesia services:

1. Inhalation
2. Regional
   - Spinal (low spinal, saddle block)
   - Epidural (caudal)
   - Nerve block (retrobulbar, brachial plexus block, etc.)
   - Field block
3. Intravenous
4. Rectal
5. Conscious sedation

Anesthesia for diagnostic or therapeutic nerve blocks and injections (codes 01991 and 01992) are eligible for reimbursement when the block or injection is performed by a different provider. Local anesthesia (A9270), which is direct infiltration of the incision, wound, or lesion is not a covered service.

Reimbursement for anesthesia services is based on the use of relative value units, including base units, plus time units and eligible modifying units when appropriate, multiplied by a monetary conversion factor.

The basic value for anesthesia when multiple surgical procedures are performed is the basic value for the procedure with the highest unit value. Reimbursement is not allowed for the basic unit value of a second, third, etc., procedure.

Anesthesia time begins when the anesthesiologist or CRNA is first in attendance with the patient for the purpose of creating the anesthetic state. Anesthesia time ends when the anesthesiologist or CRNA is no longer in personal attendance; that is, when the patient may be safely placed under customary postoperative supervision. This time must be documented on the anesthesia record, but not on the claim.

Time must be indicated on all anesthesia claims. Report the actual time spent administering anesthesia as minutes on the claim in the "days or units" block. The Plan will convert total minutes to time units. A "time unit" is a measure of each fifteen (15) minute interval or the actual time reported. Time units are calculated by dividing the total minutes of anesthesia time reported by fifteen (15), rounding to one decimal place (e.g., total anesthesia time of 48 minutes divided by 15 equals 3.2 time units).

Note: Report units, not minutes for moderate (conscious) sedation.

Applicable codes: 01991 01992 A9270 J0670 J2001 J2795 S0020

Direction of Anesthesia Services

The amount for physician anesthesia services is based on allowable base and time units multiplied by an anesthesia conversion factor.

Concurrent directed anesthesia procedures are defined with regard to the maximum number of procedures that the physician is directing within the context of a single procedure.

Physicians must report the appropriate anesthesia modifier to denote whether the service was personally performed, directed, or supervised.

Specific anesthesia modifiers include:

AA - Anesthesia Services performed personally by the anesthesiologist

AD - Medical Supervision by a physician; more than 4 concurrent anesthesia procedures

G8 - Monitored anesthesia care (MAC) for deep complex complicated or markedly invasive surgical procedures

G9 - Monitored anesthesia care for patient who has a history of severe cardio-pulmonary condition

QK - Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals

QS - Monitored anesthesia care service

QX - CRNA service; with medical direction by a physician

QY - Medical direction of one certified registered nurse anesthetist by an anesthesiologist

QZ - CRNA service: without medical direction by a physician

Note: The QS modifier is for informational purposes. Providers must report actual anesthesia time on the claim.

Modifying Units for Anesthesia Services

The Plan does not separately reimburse for the following codes 99100, 99140, 99116 or 99135.

Monitoring Services Performed in Conjunction with the Administration of Anesthesia

The reporting of anesthesia services is appropriate by or under the responsible supervision of a physician. These services may include but are not limited to general, regional, supplementation of local anesthesia, or other supportive services to afford the patient the anesthesia care deemed optimal by the anesthesiologist during any procedure.

If monitoring services are reported on the same day as anesthesia, and the charges are itemized, the Plan will combine the charges and reimburse only the anesthesia. Reimbursement for the anesthesia performed on the same date of service includes the allowance for these services and are not eligible as a separate and distinct service. A participating or network provider cannot separately bill the member for these services. If these services are independently performed, report the service with modifier 59.

The Plan considers pre-operative and post-operative visits part of the global anesthesia allowance.

Examples of monitoring procedures performed during the course of administering anesthesia or for purposes of intraoperative anesthesia management are:

- ECG/EKG monitoring
- Administration of fluids and/or blood
- Respiratory functions (i.e., oxygen saturation [oximetry], end-tidal CO2 monitoring [capnography], etc.)
- Temperature
- Blood Pressure
- Mass spectrometry (Commercial products only)

Note: Modifier 59 may be reported with a non-E/M service, to identify it as distinct or independent from other non-E/M services performed on the same day. When modifier 59 is reported, the patient medical record must support its use in accordance with CPT guidelines.

Applicable Codes:

36430 36440 36450 36455 36460 83789 93000 93005 93010 93040 93041
93042 94680 94681 94690 94726 94727 94728 94729 94760 94761

Medicare Advantage Applicable Codes:

36430 36440 93000 93005 93010 93040 93041 93042 94680 94681 94690
94760 94761

Continuous Local Delivery of Analgesia to Operative Sites Using an Elastomeric Infusion Pump

Continuous infusion of an analgesic to operative wound sites is a technique for postoperative pain control for surgeries typically requiring oral or parenteral narcotics.

Local delivery of analgesia to operative sites is designed to reduce postoperative pain, while limiting systemic side effects of analgesia. Additional benefits include reduced need for oral narcotics, decreased incidence of breakthrough pain, and faster return to normal activities. Drug delivery can be regulated through the use of simple disposable elastomeric pumps filled with analgesics attached to a variety of catheters that provide continuous delivery of the drug to the surgical site. Catheters may contain multiple openings so that the drug seeps into the operative wound all along its length. Elastomeric infusion pumps are designed to deliver drugs for up to five days followed by removal of the catheter. Elastomeric pumps to deliver local analgesia have been used postoperatively for the following:

- Orthopedic procedures, such as repair of the anterior cruciate ligament
- Urology procedures, such as prostatectomy
- Plastic surgery procedures
- Obstetrical/gynecologic procedures, such as cesarean section
- Gastrointestinal surgery procedures, such as hemorrhoidectomy or gastric bypass
- Thoracic surgery procedures, such as thoracotomy
- Cardiovascular surgery procedures, such as sternotomy

Only elastomeric pumps and associated catheters that have received approval from the US Food and Drug Administration (FDA) are to be used.

Reimbursement for catheter insertion and removal to provide continuous delivery of a drug to a surgical site is included in the allowance for the surgery and therefore, is not eligible for separate reimbursement.

The elastomeric infusion pump (codes A4305 and A4306) is a supply most commonly reported as a facility expense. However, when reported by the doctor, coverage for the elastomeric infusion pump is determined according to individual or group customer benefits.

Position Units

No allowance will be made for position. If extenuating circumstances exist in connection with the position of a patient, the services may be appealed for consideration by medical review.

Up to and including four (4) additional modifying units may be allowed when the anesthesiologist requests additional units for general anesthesia for congenital cataract extraction.

It will be necessary for the provider to submit medical records and/or additional documentation to determine coverage in this situation.

Anesthesia Services Prior to Postponement of Surgery

The Plan uses the following guidelines to adjudicate claims for the administration of anesthesia prior to the postponement of surgery:

1. If surgery is cancelled because of the anesthesiologist's preoperative appraisal, reimbursement can be made on the basis of a consultation. (Coverage for consultations is determined according to individual or group customer benefits.)
2. When surgery is aborted after general or regional anesthesia induction has taken place, reimbursement is made on the basis of 3 basic units plus time units multiplied by the conversion factor.
3. If anesthesia is reported under an NOC/NOS code, the Plan will adjudicate claims for the administration of anesthesia prior to the postponement of surgery, according to policy guidelines.

Payment for Personally Performed Anesthesia

Anesthesia payment is determined by the base unit for the anesthesia code and one time unit per 15 minutes of anesthesia time if:

1. The physician personally performed the entire anesthesia service alone, **or**;
2. The physician is a teaching physician involved with one or two concurrent resident cases or in one resident case that is concurrent to another case paid under medical direction payment rules (i.e., a nurse anesthetist or anesthesiologists' assistant case), **or**
3. The physician is continuously involved in a single case involving a student nurse anesthetist, **or**
4. If the physician is involved with a single case with a CRNA or an anesthesia assistant (AA), payment can be for the physician service and the CRNA (or AA) service in accordance with the medical direction payment policy, **or**
5. The physician and the CRNA (or AA) is involved in one anesthesia case and the services of each are found to be necessary. Documentation must be submitted by both the CRNA and the physician to support payment of the full fee for each of the two providers. The physician reports the "AA" modifier and the CRNA reports the "QZ" modifier for a non-necessary case.

Payment for Directed Anesthesia

Payment for the physician's directed service is determined on the basis of fifty (50) percent of the allowance for the service performed by the physician alone. Direction occurs if the physician directs qualified individuals in two, three, or four concurrent cases and the physician performs the following activities:

1. Performs a pre-anesthetic examination and evaluation;
2. Prescribes the anesthesia plan;
3. Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence;
4. Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist;
5. Monitors the course of anesthesia administration at frequent intervals;
6. Remains physically present and available for immediate diagnosis and treatment of emergencies; and
7. Provides indicated-post-anesthesia care.

The physician must participate only in the most demanding procedures of the anesthesia plan, including if applicable, induction and emergence. Also, for directed services, the physician must document in the medical record he or she performed the pre-anesthetic examination and evaluation. Physicians must also document they provided indicated post-anesthesia care, were present during some portion of the anesthesia monitoring, and were present during the most demanding procedures, including induction and emergence, where indicated.

The physician can direct two, three, or four concurrent procedures involving qualified individuals, all of whom could be CRNAs, AAs, interns, residents, or combinations of these individuals. The direction rules apply to cases involving student nurse anesthetists if the physician directs two concurrent cases, each of which involves a student nurse anesthetist, or the physician directs one case involving a student nurse anesthetist and another involving a CRNA, AA, intern, or resident.

A physician who is concurrently directing the administration of anesthesia to not more than four surgical patients cannot ordinarily be involved in performing additional services to other patients. However, addressing an emergency of short duration in the immediate area, administering an epidural or caudal

anesthetic to ease labor pain, or periodic, rather than continuous, monitoring of an obstetrical patient does not substantially diminish the scope of control exercised by the physician in directing the administration of anesthesia to surgical patients. It does not constitute a separate service for the purpose of determining whether the direction criteria are met. Further, while directing concurrent anesthesia procedures, a physician may receive patients entering the operating suite for the next surgery, check or discharge patients in the recovery room, or handle scheduling matters without affecting fee schedule payment.

However, if the physician leaves the immediate area of the operating suite for other than short durations or devotes extensive time to an emergency case or is otherwise not available to respond to the immediate needs of the surgical patients, the physician's services to the surgical patients are supervisory in nature and reimbursement cannot be made.

Only three base units per procedure may be allowed when the anesthesiologist is involved in performing more than four procedures concurrently or is performing other services while directing the concurrent procedures. An additional time unit may be recognized if the physician can document that they were personally present at induction.

If anesthesiologists are in a group practice, one physician member may provide the pre-anesthesia examination and evaluation while another fulfills the other criteria. Similarly, one physician member of the group may provide post-anesthesia care while another member of the group performs the other component parts of the anesthesia service. However, the patient medical record must indicate the services were performed by physicians and identify the physicians who performed them.

Anesthesia Services Provided by a Qualified Anesthetist

Reimbursement will be made for directed services when only one service is supervised. The payment amount for the physician service and the CRNA service is fifty (50) percent (for each service) of the allowance otherwise recognized had the service been furnished solely by the anesthesiologist. Modifier QX should be appended to the procedure code(s) in these cases.

Note: This section is not applicable to the West Virginia Region

Screening Colonoscopy

When a screening colonoscopy becomes a diagnostic colonoscopy, anesthesia services are reported with CPT code 00811 (Anesthesia for lower intestinal endoscopic procedures, endoscopy introduced distal to duodenum; not otherwise specified) and with the PT modifier.

Modifier PT – Colorectal cancer screening test; converted to diagnostic test or other procedure

Dental Anesthesia

The Plan uses the following guidelines from the American Dental Association (ADA) for reporting dental anesthesia services. For the initial 15 minutes of anesthesia services provided using the appropriate Common Dental Terminology (CDT) Code:

D9222 – for deep sedation/general anesthesia, initial 15 minutes.

D9239 – for intravenous moderate (conscious) sedation/analgesia, initial 15 minutes.

Note: Base unit values will apply only to the initial 15 mins of service. Submit as one unit.

Submit subsequent 15-minute increments of anesthesia services provided (after the initial 15 minutes) using the appropriate CDT code:

D9223 – for deep sedation/general anesthesia, each subsequent 15-minute increment

D9243 – for intravenous moderate (conscience) sedation/analgesia, each subsequent 15-minute increment.

Note: Please bill one unit for every 15 minutes of anesthesia time on a separate claim line.

Labor and Delivery *(Commercial Only)*

Anesthesia for Obstetrics services would focus on management of pregnant patients during labor, non-operative delivery, operative delivery, and selected aspects of postpartum care.

Commercial Applicable Codes:

01958 01960 01961 01962 01963 01965 01966 01967 01968 01969

Add-on codes are always performed in addition to the primary service or procedure and must never be reported as a standalone code on a separate claim. In situations where obstetrical anesthesia for planned vaginal delivery begins on one day and ends in caesarean delivery on the following day, the date of service for both codes (01967 and 01968) should be the date of delivery. Codes should not be reported on separate claims or span multiple dates of service. Add-on codes submitted with no primary code or a different date of service result in rejection and non-payment of the add-on code.

Physical Status Units *(Commercial Only)*

Patient physical status should be reported under the appropriate modifier (P1-P6).

Physical Status I (Modifier P1): Units allowed = 0

- This modifier represents a normally healthy patient. There is no organic, physiologic, biochemical, or psychiatric disturbance. The pathological process for which the operation is to be performed is localized and not conducive to systemic disturbance.

Physical Status II (Modifier P2): Units allowed = 0

- This modifier represents a patient with mild to moderate systemic disturbance caused either by the condition to be treated surgically or by other pathophysiologic processes.

Physical Status III (Modifier P3): Units allowed = 1

- This modifier represents a patient with severe systemic disease.

Physical Status IV (Modifier P4): Units allowed = 2

- This modifier represents a patient with severe systemic disorder already life threatening and not always correctable by operative procedures.

Physical Status V (Modifier P5): Units allowed = 3

- This modifier represents a moribund patient who has little chance of survival but is submitted to operation in desperation. This classification is rarely used.

Physical Status VI (Modifier P6): Units allowed = 0

RELATED HIGHMARK POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-025: Implantation of Subcutaneous Intravascular Catheter
- RP-009: Modifiers 25, 59, XE, XP, XS and XU
- RP-041 Services not Separately Reimbursed

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

- Provider Communication issued 11.30.18

REFERENCES:

- CMS Online Manual Publication: 100-04, Chapter 12, Section 50
- Current Procedural Terminology (CPT)
- National Uniform Billing committee

POLICY UPDATE HISTORY INFORMATION:

3 / 2018	Implementation
8 / 2019	Added Dental, Labor and Delivery
10 / 2019	Added additional verbiage related to Dental, Labor and Delivery
10 / 2021	Added NY region applicable to the policy with note for NY under Modifying Units section
12 / 2021	Added the plan will not separately reimburse for modifying units
6 / 2022	Removed CPT 94770, 94750. Removed MA Medical Policy N-118
10 / 2022	Removed MP N-118 verbiage from page 6

Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP-033		
Subject:	Anesthesia Services		
Effective Date:	March 12, 2018	**End Date:**	
Issue Date:	July 18, 2022	**Revised Date:**	June 2022
Date Reviewed:	June 2022		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Claim Type	**UB**	☐	**1500**	☒			

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

This policy is to provide direction on the Plan's reimbursement of anesthesia services.

REIMBURSEMENT GUIDELINES:

The following types of anesthesia qualify for reimbursement as anesthesia services:

1. Inhalation
2. Regional
    - Spinal (low spinal, saddle block)
    - Epidural (caudal)
    - Nerve block (retrobulbar, brachial plexus block, etc.)
    - Field block
3. Intravenous
4. Rectal
5. Conscious sedation

Anesthesia for diagnostic or therapeutic nerve blocks and injections (codes 01991 and 01992) are eligible for reimbursement when the block or injection is performed by a different provider. Local anesthesia (A9270), which is direct infiltration of the incision, wound, or lesion is not a covered service.

Reimbursement for anesthesia services is based on the use of relative value units, including base units, plus time units and eligible modifying units when appropriate, multiplied by a monetary conversion factor.

The basic value for anesthesia when multiple surgical procedures are performed is the basic value for the procedure with the highest unit value. Reimbursement is not allowed for the basic unit value of a second, third, etc., procedure.

Anesthesia time begins when the anesthesiologist or CRNA is first in attendance with the patient for the purpose of creating the anesthetic state. Anesthesia time ends when the anesthesiologist or CRNA is no longer in personal attendance; that is, when the patient may be safely placed under customary postoperative supervision. This time must be documented on the anesthesia record, but not on the claim.

Time must be indicated on all anesthesia claims. Report the actual time spent administering anesthesia as minutes on the claim in the "days or units" block. The Plan will convert total minutes to time units. A "time unit" is a measure of each fifteen (15) minute interval or the actual time reported. Time units are calculated by dividing the total minutes of anesthesia time reported by fifteen (15), rounding to one decimal place (e.g., total anesthesia time of 48 minutes divided by 15 equals 3.2 time units).

Note: Report units, not minutes for moderate (conscious) sedation.

Applicable codes: 01991 01992 A9270 J0670 J2001 J2795 S0020

Direction of Anesthesia Services

The amount for physician anesthesia services is based on allowable base and time units multiplied by an anesthesia conversion factor.

Concurrent directed anesthesia procedures are defined with regard to the maximum number of procedures that the physician is directing within the context of a single procedure.

Physicians must report the appropriate anesthesia modifier to denote whether the service was personally performed, directed, or supervised.

Specific anesthesia modifiers include:

AA - Anesthesia Services performed personally by the anesthesiologist

AD - Medical Supervision by a physician; more than 4 concurrent anesthesia procedures

G8 - Monitored anesthesia care (MAC) for deep complex complicated or markedly invasive surgical procedures

G9 - Monitored anesthesia care for patient who has a history of severe cardio-pulmonary condition

QK - Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals

QS - Monitored anesthesia care service

QX - CRNA service; with medical direction by a physician

QY - Medical direction of one certified registered nurse anesthetist by an anesthesiologist

QZ - CRNA service: without medical direction by a physician

Note: The QS modifier is for informational purposes. Providers must report actual anesthesia time on the claim.

Modifying Units for Anesthesia Services

The Plan does not separately reimburse for the following codes 99100, 99140, 99116 or 99135.

Monitoring Services Performed in Conjunction with the Administration of Anesthesia

The reporting of anesthesia services is appropriate by or under the responsible supervision of a physician. These services may include but are not limited to general, regional, supplementation of local anesthesia, or other supportive services to afford the patient the anesthesia care deemed optimal by the anesthesiologist during any procedure.

If monitoring services are reported on the same day as anesthesia, and the charges are itemized, the Plan will combine the charges and reimburse only the anesthesia. Reimbursement for the anesthesia performed on the same date of service includes the allowance for these services and are not eligible as a separate and distinct service. A participating or network provider cannot separately bill the member for these services. If these services are independently performed, report the service with modifier 59.

The Plan considers pre-operative and post-operative visits part of the global anesthesia allowance.

Examples of monitoring procedures performed during the course of administering anesthesia or for purposes of intraoperative anesthesia management are:

- ECG/EKG monitoring
- Administration of fluids and/or blood
- Respiratory functions (i.e., oxygen saturation [oximetry], end-tidal CO2 monitoring [capnography], etc.)
- Temperature
- Blood Pressure
- Mass spectrometry (Commercial products only)

Note: Modifier 59 may be reported with a non-E/M service, to identify it as distinct or independent from other non-E/M services performed on the same day. When modifier 59 is reported, the patient medical record must support its use in accordance with CPT guidelines.

Applicable Codes:

36430 36440 36450 36455 36460 83789 93000 93005 93010 93040 93041
93042 94680 94681 94690 94726 94727 94728 94729 94760 94761

Medicare Advantage Applicable Codes:

36430 36440 93000 93005 93010 93040 93041 93042 94680 94681 94690
94760 94761

Continuous Local Delivery of Analgesia to Operative Sites Using an Elastomeric Infusion Pump

Continuous infusion of an analgesic to operative wound sites is a technique for postoperative pain control for surgeries typically requiring oral or parenteral narcotics.

Local delivery of analgesia to operative sites is designed to reduce postoperative pain, while limiting systemic side effects of analgesia. Additional benefits include reduced need for oral narcotics, decreased incidence of breakthrough pain, and faster return to normal activities. Drug delivery can be regulated through the use of simple disposable elastomeric pumps filled with analgesics attached to a variety of catheters that provide continuous delivery of the drug to the surgical site. Catheters may contain multiple openings so that the drug seeps into the operative wound all along its length. Elastomeric infusion pumps are designed to deliver drugs for up to five days followed by removal of the catheter. Elastomeric pumps to deliver local analgesia have been used postoperatively for the following:

- Orthopedic procedures, such as repair of the anterior cruciate ligament
- Urology procedures, such as prostatectomy
- Plastic surgery procedures
- Obstetrical/gynecologic procedures, such as cesarean section
- Gastrointestinal surgery procedures, such as hemorrhoidectomy or gastric bypass
- Thoracic surgery procedures, such as thoracotomy
- Cardiovascular surgery procedures, such as sternotomy

Only elastomeric pumps and associated catheters that have received approval from the US Food and Drug Administration (FDA) are to be used.

Reimbursement for catheter insertion and removal to provide continuous delivery of a drug to a surgical site is included in the allowance for the surgery and therefore, is not eligible for separate reimbursement.

The elastomeric infusion pump (codes A4305 and A4306) is a supply most commonly reported as a facility expense. However, when reported by the doctor, coverage for the elastomeric infusion pump is determined according to individual or group customer benefits.

Position Units

No allowance will be made for position. If extenuating circumstances exist in connection with the position of a patient, the services may be appealed for consideration by medical review.

Up to and including four (4) additional modifying units may be allowed when the anesthesiologist requests additional units for general anesthesia for congenital cataract extraction.

It will be necessary for the provider to submit medical records and/or additional documentation to determine coverage in this situation.

Anesthesia Services Prior to Postponement of Surgery

The Plan uses the following guidelines to adjudicate claims for the administration of anesthesia prior to the postponement of surgery:

1. If surgery is cancelled because of the anesthesiologist's preoperative appraisal, reimbursement can be made on the basis of a consultation. (Coverage for consultations is determined according to individual or group customer benefits.)
2. When surgery is aborted after general or regional anesthesia induction has taken place, reimbursement is made on the basis of 3 basic units plus time units multiplied by the conversion factor.
3. If anesthesia is reported under an NOC/NOS code, the Plan will adjudicate claims for the administration of anesthesia prior to the postponement of surgery, according to policy guidelines.

Payment for Personally Performed Anesthesia

Anesthesia payment is determined by the base unit for the anesthesia code and one time unit per 15 minutes of anesthesia time if:

1. The physician personally performed the entire anesthesia service alone, **or**;
2. The physician is a teaching physician involved with one or two concurrent resident cases or in one resident case that is concurrent to another case paid under medical direction payment rules (i.e., a nurse anesthetist or anesthesiologists' assistant case), **or**
3. The physician is continuously involved in a single case involving a student nurse anesthetist, **or**
4. If the physician is involved with a single case with a CRNA or an anesthesia assistant (AA), payment can be for the physician service and the CRNA (or AA) service in accordance with the medical direction payment policy, **or**
5. The physician and the CRNA (or AA) is involved in one anesthesia case and the services of each are found to be necessary. Documentation must be submitted by both the CRNA and the physician to support payment of the full fee for each of the two providers. The physician reports the "AA" modifier and the CRNA reports the "QZ" modifier for a non-necessary case.

Payment for Directed Anesthesia

Payment for the physician's directed service is determined on the basis of fifty (50) percent of the allowance for the service performed by the physician alone. Direction occurs if the physician directs qualified individuals in two, three, or four concurrent cases and the physician performs the following activities:

1. Performs a pre-anesthetic examination and evaluation;
2. Prescribes the anesthesia plan;
3. Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence;
4. Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist;
5. Monitors the course of anesthesia administration at frequent intervals;
6. Remains physically present and available for immediate diagnosis and treatment of emergencies; and
7. Provides indicated-post-anesthesia care.

The physician must participate only in the most demanding procedures of the anesthesia plan, including if applicable, induction and emergence. Also, for directed services, the physician must document in the medical record he or she performed the pre-anesthetic examination and evaluation. Physicians must also document they provided indicated post-anesthesia care, were present during some portion of the anesthesia monitoring, and were present during the most demanding procedures, including induction and emergence, where indicated.

The physician can direct two, three, or four concurrent procedures involving qualified individuals, all of whom could be CRNAs, AAs, interns, residents, or combinations of these individuals. The direction rules apply to cases involving student nurse anesthetists if the physician directs two concurrent cases, each of which involves a student nurse anesthetist, or the physician directs one case involving a student nurse anesthetist and another involving a CRNA, AA, intern, or resident.

A physician who is concurrently directing the administration of anesthesia to not more than four surgical patients cannot ordinarily be involved in performing additional services to other patients. However, addressing an emergency of short duration in the immediate area, administering an epidural or caudal

anesthetic to ease labor pain, or periodic, rather than continuous, monitoring of an obstetrical patient does not substantially diminish the scope of control exercised by the physician in directing the administration of anesthesia to surgical patients. It does not constitute a separate service for the purpose of determining whether the direction criteria are met. Further, while directing concurrent anesthesia procedures, a physician may receive patients entering the operating suite for the next surgery, check or discharge patients in the recovery room, or handle scheduling matters without affecting fee schedule payment.

However, if the physician leaves the immediate area of the operating suite for other than short durations or devotes extensive time to an emergency case or is otherwise not available to respond to the immediate needs of the surgical patients, the physician's services to the surgical patients are supervisory in nature and reimbursement cannot be made.

Only three base units per procedure may be allowed when the anesthesiologist is involved in performing more than four procedures concurrently or is performing other services while directing the concurrent procedures. An additional time unit may be recognized if the physician can document that they were personally present at induction.

If anesthesiologists are in a group practice, one physician member may provide the pre-anesthesia examination and evaluation while another fulfills the other criteria. Similarly, one physician member of the group may provide post-anesthesia care while another member of the group performs the other component parts of the anesthesia service. However, the patient medical record must indicate the services were performed by physicians and identify the physicians who performed them.

Anesthesia Services Provided by a Qualified Anesthetist

Reimbursement will be made for directed services when only one service is supervised. The payment amount for the physician service and the CRNA service is fifty (50) percent (for each service) of the allowance otherwise recognized had the service been furnished solely by the anesthesiologist. Modifier QX should be appended to the procedure code(s) in these cases. For more information, please refer to medical policy N-118: *Anesthesia Services Provided by a Qualified Anesthetist.*

Note: This section is not applicable to the West Virginia Region

Screening Colonoscopy

When a screening colonoscopy becomes a diagnostic colonoscopy, anesthesia services are reported with CPT code 00811 (Anesthesia for lower intestinal endoscopic procedures, endoscopy introduced distal to duodenum; not otherwise specified) and with the PT modifier.

Modifier PT – Colorectal cancer screening test; converted to diagnostic test or other procedure

Dental Anesthesia

The Plan uses the following guidelines from the American Dental Association (ADA) for reporting dental anesthesia services. For the initial 15 minutes of anesthesia services provided using the appropriate Common Dental Terminology (CDT) Code:

D9222 – for deep sedation/general anesthesia, initial 15 minutes.

D9239 – for intravenous moderate (conscious) sedation/analgesia, initial 15 minutes.

Note: Base unit values will apply only to the initial 15 mins of service. Submit as one unit.

Submit subsequent 15-minute increments of anesthesia services provided (after the initial 15 minutes) using the appropriate CDT code:

D9223 – for deep sedation/general anesthesia, each subsequent 15-minute increment

D9243 – for intravenous moderate (conscience) sedation/analgesia, each subsequent 15-minute increment.

Note: Please bill one unit for every 15 minutes of anesthesia time on a separate claim line.

Labor and Delivery *(Commercial Only)*

Anesthesia for Obstetrics services would focus on management of pregnant patients during labor, non-operative delivery, operative delivery, and selected aspects of postpartum care.

Commercial Applicable Codes:

01958 01960 01961 01962 01963 01965 01966 01967 01968 01969

Add-on codes are always performed in addition to the primary service or procedure and must never be reported as a standalone code on a separate claim. In situations where obstetrical anesthesia for planned vaginal delivery begins on one day and ends in caesarean delivery on the following day, the date of service for both codes (01967 and 01968) should be the date of delivery. Codes should not be reported on separate claims or span multiple dates of service. Add-on codes submitted with no primary code or a different date of service result in rejection and non-payment of the add-on code.

Physical Status Units *(Commercial Only)*

Patient physical status should be reported under the appropriate modifier (P1-P6).

Physical Status I (Modifier P1): Units allowed = 0

- This modifier represents a normally healthy patient. There is no organic, physiologic, biochemical, or psychiatric disturbance. The pathological process for which the operation is to be performed is localized and not conducive to systemic disturbance.

Physical Status II (Modifier P2): Units allowed = 0

- This modifier represents a patient with mild to moderate systemic disturbance caused either by the condition to be treated surgically or by other pathophysiologic processes.

Physical Status III (Modifier P3): Units allowed = 1

- This modifier represents a patient with severe systemic disease.

Physical Status IV (Modifier P4): Units allowed = 2

- This modifier represents a patient with severe systemic disorder already life threatening and not always correctable by operative procedures.

Physical Status V (Modifier P5): Units allowed = 3

- This modifier represents a moribund patient who has little chance of survival but is submitted to operation in desperation. This classification is rarely used.

Physical Status VI (Modifier P6): Units allowed = 0

RELATED HIGHMARK POLICIES:

Refer to the following Reimbursement Policies for additional information:

- RP-025: Implantation of Subcutaneous Intravascular Catheter
- RP-009: Modifiers 25, 59, XE, XP, XS and XU
- RP-041 Services not Separately Reimbursed

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

- Provider Communication issued 11.30.18

REFERENCES:

- CMS Online Manual Publication: 100-04, Chapter 12, Section 50
- Current Procedural Terminology (CPT)
- National Uniform Billing committee

POLICY UPDATE HISTORY INFORMATION:

3 / 2018	Implementation
8 / 2019	Added Dental, Labor and Delivery
10 / 2019	Added additional verbiage related to Dental, Labor and Delivery
10 / 2021	Added NY region applicable to the policy with note for NY under Modifying Units section
12 / 2021	Added the plan will not separately reimburse for modifying units
6 / 2022	Removed CPT 94770, 94750. Removed MA Medical Policy N-118

Highmark Reimbursement Policy Bulletin

HISTORY VERSION

Bulletin Number:	RP-033		
Subject:	Anesthesia Services		
Effective Date:	March 12, 2018	**End Date:**	
Issue Date:	December 7, 2021	**Revised Date:**	October 2021
Date Reviewed:	October 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY**	☒
Applicable Claim Type	**UB**	☐	**1500**	☒				

A checked box indicates the policy is applicable to that market either entirely, or partially, as indicated within the policy.

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this policy.

PURPOSE:

This policy is to provide direction on the Plan's reimbursement of anesthesia services.

REIMBURSEMENT GUIDELINES:

The following types of anesthesia qualify for reimbursement as anesthesia services:

1. Inhalation
2. Regional
   - Spinal (low spinal, saddle block)
   - Epidural (caudal)
   - Nerve block (retrobulbar, brachial plexus block, etc.)
   - Field block
3. Intravenous
4. Rectal
5. Conscious sedation

Anesthesia for diagnostic or therapeutic nerve blocks and injections (codes 01991 and 01992) are eligible for reimbursement when the block or injection is performed by a different provider. Local anesthesia (A9270), which is direct infiltration of the incision, wound, or lesion is not a covered service.

Reimbursement for anesthesia services is based on the use of relative value units, including base units, plus time units and eligible modifying units when appropriate, multiplied by a monetary conversion factor.

The basic value for anesthesia when multiple surgical procedures are performed is the basic value for the procedure with the highest unit value. Reimbursement is not allowed for the basic unit value of a second, third, etc., procedure.

Anesthesia time begins when the anesthesiologist or CRNA is first in attendance with the patient for the purpose of creating the anesthetic state. Anesthesia time ends when the anesthesiologist or CRNA is no longer in personal attendance; that is, when the patient may be safely placed under customary postoperative supervision. This time must be documented on the anesthesia record, but not on the claim.

Time must be indicated on all anesthesia claims. Report the actual time spent administering anesthesia as minutes on the claim in the "days or units" block. The Plan will convert total minutes to time units. A "time unit" is a measure of each fifteen (15) minute interval or the actual time reported. Time units are calculated by dividing the total minutes of anesthesia time reported by fifteen (15), rounding to one decimal place (e.g., total anesthesia time of 48 minutes divided by 15 equals 3.2 time units).

Note: Report units, not minutes for moderate (conscious) sedation.

Applicable codes: 01991 01992 A9270 J0670 J2001 J2795 S0020

Direction of Anesthesia Services

The amount for physician anesthesia services is based on allowable base and time units multiplied by an anesthesia conversion factor.

Concurrent directed anesthesia procedures are defined with regard to the maximum number of procedures that the physician is directing within the context of a single procedure.

Physicians must report the appropriate anesthesia modifier to denote whether the service was personally performed, directed, or supervised.

Specific anesthesia modifiers include:

AA - Anesthesia Services performed personally by the anesthesiologist

AD - Medical Supervision by a physician; more than 4 concurrent anesthesia procedures

G8 - Monitored anesthesia care (MAC) for deep complex complicated or markedly invasive surgical procedures

G9 - Monitored anesthesia care for patient who has a history of severe cardio-pulmonary condition

QK - Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals

QS - Monitored anesthesia care service

QX - CRNA service; with medical direction by a physician

QY - Medical direction of one certified registered nurse anesthetist by an anesthesiologist

QZ - CRNA service: without medical direction by a physician

Note: The QS modifier is for informational purposes. Providers must report actual anesthesia time on the claim.

Modifying Units for Anesthesia Services

The Plan does not separately reimburse for the following codes 99100, 99140, 99116 or 99135.

Monitoring Services Performed in Conjunction with the Administration of Anesthesia

The reporting of anesthesia services is appropriate by or under the responsible supervision of a physician. These services may include but are not limited to general, regional, supplementation of local anesthesia, or other supportive services to afford the patient the anesthesia care deemed optimal by the anesthesiologist during any procedure.

If monitoring services are reported on the same day as anesthesia, and the charges are itemized, the Plan will combine the charges and reimburse only the anesthesia. Reimbursement for the anesthesia performed on the same date of service includes the allowance for these services and are not eligible as a separate and distinct service. A participating or network provider cannot separately bill the member for these services. If these services are independently performed, report the service with modifier 59.

The Plan considers pre-operative and post-operative visits part of the global anesthesia allowance.

Examples of monitoring procedures performed during the course of administering anesthesia or for purposes of intraoperative anesthesia management are:

- ECG/EKG monitoring
- Administration of fluids and/or blood
- Respiratory functions (i.e., oxygen saturation [oximetry], end-tidal CO2 monitoring [capnography], etc.)
- Temperature
- Blood Pressure
- Mass spectrometry (Commercial products only)

Note: Modifier 59 may be reported with a non-E/M service, to identify it as distinct or independent from other non-E/M services performed on the same day. When modifier 59 is reported, the patient medical record must support its use in accordance with CPT guidelines.

Applicable Codes:

36430 36440 36450 36455 36460 83789 93000 93005 93010 93040 93041 93042 94680 94681 94690 94726 94727 94728 94729 94750 94760 94761 94770

Medicare Advantage Applicable Codes:

36430 36440 93000 93005 93010 93040 93041 93042 94680 94681 94690 94760 94761 94770

Continuous Local Delivery of Analgesia to Operative Sites Using an Elastomeric Infusion Pump

Continuous infusion of an analgesic to operative wound sites is a technique for postoperative pain control for surgeries typically requiring oral or parenteral narcotics.

Local delivery of analgesia to operative sites is designed to reduce postoperative pain, while limiting systemic side effects of analgesia. Additional benefits include reduced need for oral narcotics, decreased incidence of breakthrough pain, and faster return to normal activities. Drug delivery can be regulated through the use of simple disposable elastomeric pumps filled with analgesics attached to a variety of catheters that provide continuous delivery of the drug to the surgical site. Catheters may contain multiple openings so that the drug seeps into the operative wound all along its length. Elastomeric infusion pumps are designed to deliver drugs for up to five days followed by removal of the catheter. Elastomeric pumps to deliver local analgesia have been used postoperatively for the following:

- Orthopedic procedures, such as repair of the anterior cruciate ligament
- Urology procedures, such as prostatectomy
- Plastic surgery procedures
- Obstetrical/gynecologic procedures, such as cesarean section
- Gastrointestinal surgery procedures, such as hemorrhoidectomy or gastric bypass
- Thoracic surgery procedures, such as thoracotomy
- Cardiovascular surgery procedures, such as sternotomy

Only elastomeric pumps and associated catheters that have received approval from the US Food and Drug Administration (FDA) are to be used.

Reimbursement for catheter insertion and removal to provide continuous delivery of a drug to a surgical site is included in the allowance for the surgery and therefore, is not eligible for separate reimbursement.

The elastomeric infusion pump (codes A4305 and A4306) is a supply most commonly reported as a facility expense. However, when reported by the doctor, coverage for the elastomeric infusion pump is determined according to individual or group customer benefits.

Position Units

No allowance will be made for position. If extenuating circumstances exist in connection with the position of a patient, the services may be appealed for consideration by medical review.

Up to and including four (4) additional modifying units may be allowed when the anesthesiologist requests additional units for general anesthesia for congenital cataract extraction.

It will be necessary for the provider to submit medical records and/or additional documentation to determine coverage in this situation.

Anesthesia Services Prior to Postponement of Surgery

The Plan uses the following guidelines to adjudicate claims for the administration of anesthesia prior to the postponement of surgery:

1. If surgery is cancelled because of the anesthesiologist's preoperative appraisal, reimbursement can be made on the basis of a consultation. (Coverage for consultations is determined according to individual or group customer benefits.)
2. When surgery is aborted after general or regional anesthesia induction has taken place, reimbursement is made on the basis of 3 basic units plus time units multiplied by the conversion factor.
3. If anesthesia is reported under an NOC/NOS code, the Plan will adjudicate claims for the administration of anesthesia prior to the postponement of surgery, according to policy guidelines.

Payment for Personally Performed Anesthesia

Anesthesia payment is determined by the base unit for the anesthesia code and one time unit per 15 minutes of anesthesia time if:

1. The physician personally performed the entire anesthesia service alone, **or**;
2. The physician is a teaching physician involved with one or two concurrent resident cases or in one resident case that is concurrent to another case paid under medical direction payment rules (i.e., a nurse anesthetist or anesthesiologists' assistant case), **or**
3. The physician is continuously involved in a single case involving a student nurse anesthetist, **or**
4. If the physician is involved with a single case with a CRNA or an anesthesia assistant (AA), payment can be for the physician service and the CRNA (or AA) service in accordance with the medical direction payment policy, **or**
5. The physician and the CRNA (or AA) is involved in one anesthesia case and the services of each are found to be necessary. Documentation must be submitted by both the CRNA and the physician to support payment of the full fee for each of the two providers. The physician reports the "AA" modifier and the CRNA reports the "QZ" modifier for a non-necessary case.

Payment for Directed Anesthesia

Payment for the physician's directed service is determined on the basis of fifty (50) percent of the allowance for the service performed by the physician alone. Direction occurs if the physician directs qualified individuals in two, three, or four concurrent cases and the physician performs the following activities:

1. Performs a pre-anesthetic examination and evaluation;
2. Prescribes the anesthesia plan;
3. Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence;
4. Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist;
5. Monitors the course of anesthesia administration at frequent intervals;
6. Remains physically present and available for immediate diagnosis and treatment of emergencies; and
7. Provides indicated-post-anesthesia care.

The physician must participate only in the most demanding procedures of the anesthesia plan, including if applicable, induction and emergence. Also, for directed services, the physician must document in the medical record he or she performed the pre-anesthetic examination and evaluation. Physicians must also document they provided indicated post-anesthesia care, were present during some portion of the anesthesia monitoring, and were present during the most demanding procedures, including induction and emergence, where indicated.

The physician can direct two, three, or four concurrent procedures involving qualified individuals, all of whom could be CRNAs, AAs, interns, residents, or combinations of these individuals. The direction rules apply to cases involving student nurse anesthetists if the physician directs two concurrent cases, each of which involves a student nurse anesthetist, or the physician directs one case involving a student nurse anesthetist and another involving a CRNA, AA, intern, or resident.

A physician who is concurrently directing the administration of anesthesia to not more than four surgical patients cannot ordinarily be involved in performing additional services to other patients. However, addressing an emergency of short duration in the immediate area, administering an epidural or caudal

anesthetic to ease labor pain, or periodic, rather than continuous, monitoring of an obstetrical patient does not substantially diminish the scope of control exercised by the physician in directing the administration of anesthesia to surgical patients. It does not constitute a separate service for the purpose of determining whether the direction criteria are met. Further, while directing concurrent anesthesia procedures, a physician may receive patients entering the operating suite for the next surgery, check or discharge patients in the recovery room, or handle scheduling matters without affecting fee schedule payment.

However, if the physician leaves the immediate area of the operating suite for other than short durations or devotes extensive time to an emergency case or is otherwise not available to respond to the immediate needs of the surgical patients, the physician's services to the surgical patients are supervisory in nature and reimbursement cannot be made.

Only three base units per procedure may be allowed when the anesthesiologist is involved in performing more than four procedures concurrently or is performing other services while directing the concurrent procedures. An additional time unit may be recognized if the physician can document that they were personally present at induction.

If anesthesiologists are in a group practice, one physician member may provide the pre-anesthesia examination and evaluation while another fulfills the other criteria. Similarly, one physician member of the group may provide post-anesthesia care while another member of the group performs the other component parts of the anesthesia service. However, the patient medical record must indicate the services were performed by physicians and identify the physicians who performed them.

Anesthesia Services Provided by a Qualified Anesthetist

Reimbursement will be made for directed services when only one service is supervised. The payment amount for the physician service and the CRNA service is fifty (50) percent (for each service) of the allowance otherwise recognized had the service been furnished solely by the anesthesiologist. Modifier QX should be appended to the procedure code(s) in these cases. For more information, please refer to medical policy N-118: *Anesthesia Services Provided by a Qualified Anesthetist.*

Note: This section is not applicable to the West Virginia Region

Screening Colonoscopy

When a screening colonoscopy becomes a diagnostic colonoscopy, anesthesia services are reported with CPT code 00811 (Anesthesia for lower intestinal endoscopic procedures, endoscopy introduced distal to duodenum; not otherwise specified) and with the PT modifier.

Modifier PT – Colorectal cancer screening test; converted to diagnostic test or other procedure

Dental Anesthesia

The Plan uses the following guidelines from the American Dental Association (ADA) for reporting dental anesthesia services. For the initial 15 minutes of anesthesia services provided using the appropriate Common Dental Terminology (CDT) Code:

D9222 – for deep sedation/general anesthesia, initial 15 minutes.

D9239 – for intravenous moderate (conscious) sedation/analgesia, initial 15 minutes.

Note: Base unit values will apply only to the initial 15 mins of service. Submit as one unit.

Submit subsequent 15-minute increments of anesthesia services provided (after the initial 15 minutes) using the appropriate CDT code:

D9223 – for deep sedation/general anesthesia, each subsequent 15-minute increment

D9243 – for intravenous moderate (conscience) sedation/analgesia, each subsequent 15-minute increment.

Note: Please bill one unit for every 15 minutes of anesthesia time on a separate claim line.

Labor and Delivery *(Commercial Only)*

Anesthesia for Obstetrics services would focus on management of pregnant patients during labor, non-operative delivery, operative delivery, and selected aspects of postpartum care.

Commercial Applicable Codes:

01958 01960 01961 01962 01963 01965 01966 01967 01968 01969

Add-on codes are always performed in addition to the primary service or procedure and must never be reported as a standalone code on a separate claim. In situations where obstetrical anesthesia for planned vaginal delivery begins on one day and ends in caesarean delivery on the following day, the date of service for both codes (01967 and 01968) should be the date of delivery. Codes should not be reported on separate claims or span multiple dates of service. Add-on codes submitted with no primary code or a different date of service result in rejection and non-payment of the add-on code.

Physical Status Units *(Commercial Only)*

Patient physical status should be reported under the appropriate modifier (P1-P6).

Physical Status I (Modifier P1): Units allowed = 0

- This modifier represents a normally healthy patient. There is no organic, physiologic, biochemical, or psychiatric disturbance. The pathological process for which the operation is to be performed is localized and not conducive to systemic disturbance.

Physical Status II (Modifier P2): Units allowed = 0

- This modifier represents a patient with mild to moderate systemic disturbance caused either by the condition to be treated surgically or by other pathophysiologic processes.

Physical Status III (Modifier P3): Units allowed = 1

- This modifier represents a patient with severe systemic disease.

Physical Status IV (Modifier P4): Units allowed = 2

- This modifier represents a patient with severe systemic disorder already life threatening and not always correctable by operative procedures.

Physical Status V (Modifier P5): Units allowed = 3

- This modifier represents a moribund patient who has little chance of survival but is submitted to operation in desperation. This classification is rarely used.

Physical Status VI (Modifier P6): Units allowed = 0

RELATED HIGHMARK POLICIES:

Refer to the following Medicare Advantage Medical Policies for additional information:

- N-118: Anesthesia Services Provided by a Qualified Anesthetist

Refer to the following Reimbursement Policies for additional information:

- RP-025: Implantation of Subcutaneous Intravascular Catheter
- RP-009: Modifiers 25, 59, XE, XP, XS and XU
- RP-041 Services not Separately Reimbursed

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

- Provider Communication issued 11.30.18

REFERENCES:

- CMS Online Manual Publication: 100-04, Chapter 12, Section 50
- Current Procedural Terminology (CPT)
- National Uniform Billing committee

POLICY UPDATE HISTORY INFORMATION:

3 / 2018	Implementation
8 / 2019	Added Dental, Labor and Delivery
10 / 2019	Added additional verbiage related to Dental, Labor and Delivery
10 / 2021	Added NY region applicable to the policy with note for NY under Modifying Units section
12 / 2021	Added the plan will not separately reimburse for modifying units

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSION

Bulletin Number:	RP-033		
Subject:	Anesthesia Services		
Effective Date:	March 12, 2018	**End Date:**	
Issue Date:	October 1, 2021	**Revised Date:**	July 2021
Date Reviewed:	July 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV**	☒	**DE**	☒	**NY** ☒
Applicable Medicare Advantage Market	**PA**	☒	**WV**	☒	**DE**	☐	**NY** ☒
Applicable Claim Type	**UB**	☐	**1500**	☒			

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this Policy.

PURPOSE:

This policy is to provide direction on the Plan's reimbursement of anesthesia services.

REIMBURSEMENT GUIDELINES:

The following types of anesthesia qualify for reimbursement as anesthesia services:

1. Inhalation
2. Regional
    - Spinal (low spinal, saddle block)
    - Epidural (caudal)
    - Nerve block (retrobulbar, brachial plexus block, etc.)
    - Field block
3. Intravenous
4. Rectal
5. Conscious sedation

Anesthesia for diagnostic or therapeutic nerve blocks and injections (codes 01991 and 01992) are eligible for reimbursement when the block or injection is performed by a different provider. Local anesthesia (A9270), which is direct infiltration of the incision, wound, or lesion is not a covered service.

Reimbursement for anesthesia services is based on the use of relative value units, including base units, plus time units and eligible modifying units when appropriate, multiplied by a monetary conversion factor.

The basic value for anesthesia when multiple surgical procedures are performed is the basic value for the procedure with the highest unit value. Reimbursement is not allowed for the basic unit value of a second, third, etc., procedure.

Anesthesia time begins when the anesthesiologist or CRNA is first in attendance with the patient for the purpose of creating the anesthetic state. Anesthesia time ends when the anesthesiologist or CRNA is no longer in personal attendance; that is, when the patient may be safely placed under customary postoperative supervision. This time must be documented on the anesthesia record, but not on the claim.

Time must be indicated on all anesthesia claims. Report the actual time spent administering anesthesia as minutes on the claim in the "days or units" block. The Plan will convert total minutes to time units. A "time unit" is a measure of each fifteen (15) minute interval or the actual time reported. Time units are calculated by dividing the total minutes of anesthesia time reported by fifteen (15), rounding to one decimal place (e.g., total anesthesia time of 48 minutes divided by 15 equals 3.2 time units).

Note: Report units, not minutes for moderate (conscious) sedation.

Applicable codes: 01991 01992 A9270 J0670 J2001 J2795 S0020

Direction of Anesthesia Services

The amount for physician anesthesia services is based on allowable base and time units multiplied by an anesthesia conversion factor.

Concurrent directed anesthesia procedures are defined with regard to the maximum number of procedures that the physician is directing within the context of a single procedure.

Physicians must report the appropriate anesthesia modifier to denote whether the service was personally performed, directed, or supervised.

Specific anesthesia modifiers include:

AA - Anesthesia Services performed personally by the anesthesiologist

AD - Medical Supervision by a physician; more than 4 concurrent anesthesia procedures

G8 - Monitored anesthesia care (MAC) for deep complex complicated or markedly invasive surgical procedures

G9 - Monitored anesthesia care for patient who has a history of severe cardio-pulmonary condition

QK - Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals

QS - Monitored anesthesia care service

QX - CRNA service; with medical direction by a physician

QY - Medical direction of one certified registered nurse anesthetist by an anesthesiologist

QZ - CRNA service: without medical direction by a physician

Note: The QS modifier is for informational purposes. Providers must report actual anesthesia time on the claim.

Modifying Units for Anesthesia Services

Modifying units represent those circumstances that necessitate skills of a physician beyond those usually required. Modifying circumstances representative of age, emergency, total body hypothermia, and controlled hypotension should be reported under codes 99100, 99116, 99135 and 99140. These procedures are not associated with numbers of units and they will be reimbursed at a flat fee.

Note: Medicare Advantage does not separately reimburse codes 99100, 99116, 99135 or 99140.

Note: New York Commercial and Medicare Advantage products do not separately reimburse 99100, 99116, 99135, or 99140.

Code 99100 (Age)

- Reimbursement may be allowed for patients under one (1) year of age, or 71 years of age or older.

Code 99140 (Emergency)

- Reimbursement may be made for any service reported as an "emergency," except for a normal vaginal delivery.

Other Modifying Codes

- Reimbursement may be allowed when the doctor requests either utilization of total body hypothermia (code 99116) or utilization of controlled hypotension (99135).
- This modifier represents a declared brain-dead patient whose organs are being removed for donor purposes. If the doctor reports physical status III, IV, or V, payment may be allowed for the units listed above. If the doctor does not report physical status, no additional units will be allowed.

Monitoring Services Performed in Conjunction with the Administration of Anesthesia

The reporting of anesthesia services is appropriate by or under the responsible supervision of a physician. These services may include but are not limited to general, regional, supplementation of local anesthesia, or other supportive services to afford the patient the anesthesia care deemed optimal by the anesthesiologist during any procedure.

If monitoring services are reported on the same day as anesthesia, and the charges are itemized, the Plan will combine the charges and reimburse only the anesthesia. Reimbursement for the anesthesia performed on the same date of service includes the allowance for these services and are not eligible as a separate and distinct service. A participating or network provider cannot separately bill the member for these services. If these services are independently performed, report the service with modifier 59.

The Plan considers pre-operative and post-operative visits part of the global anesthesia allowance.

Examples of monitoring procedures performed during the course of administering anesthesia or for purposes of intraoperative anesthesia management are:

- ECG/EKG monitoring
- Administration of fluids and/or blood

- Respiratory functions (i.e. oxygen saturation [oximetry], end-tidal CO2 monitoring [capnography], etc.)
- Temperature
- Blood Pressure
- Mass spectrometry (Commercial products only)

Note: Modifier 59 may be reported with a non-E/M service, to identify it as distinct or independent from other non-E/M services performed on the same day. When modifier 59 is reported, the patient medical record must support its use in accordance with CPT guidelines.

Applicable Codes:

36430 36440 36450 36455 36460 83789 93000 93005 93010 93040 93041 93042 94680 94681 94690 94726 94727 94728 94729 94750 94760 94761 94770

Medicare Advantage Applicable Codes:

36430 36440 93000 93005 93010 93040 93041 93042 94680 94681 94690 94760 94761 94770

<u>Continuous Local Delivery of Analgesia to Operative Sites Using an Elastomeric Infusion Pump</u>

Continuous infusion of an analgesic to operative wound sites is a technique for postoperative pain control for surgeries typically requiring oral or parenteral narcotics.

Local delivery of analgesia to operative sites is designed to reduce postoperative pain, while limiting systemic side effects of analgesia. Additional benefits include reduced need for oral narcotics, decreased incidence of breakthrough pain, and faster return to normal activities. Drug delivery can be regulated through the use of simple disposable elastomeric pumps filled with analgesics attached to a variety of catheters that provide continuous delivery of the drug to the surgical site. Catheters may contain multiple openings so that the drug seeps into the operative wound all along its length. Elastomeric infusion pumps are designed to deliver drugs for up to five days followed by removal of the catheter. Elastomeric pumps to deliver local analgesia have been used postoperatively for the following:

- Orthopedic procedures, such as repair of the anterior cruciate ligament
- Urology procedures, such as prostatectomy
- Plastic surgery procedures
- Obstetrical/gynecologic procedures, such as cesarean section
- Gastrointestinal surgery procedures, such as hemorrhoidectomy or gastric bypass
- Thoracic surgery procedures, such as thoracotomy
- Cardiovascular surgery procedures, such as sternotomy

Only elastomeric pumps and associated catheters that have received approval from the US Food and Drug Administration (FDA) are to be used.

Reimbursement for catheter insertion and removal to provide continuous delivery of a drug to a surgical site is included in the allowance for the surgery and therefore, is not eligible for separate reimbursement.

The elastomeric infusion pump (codes A4305 and A4306) is a supply most commonly reported as a facility expense. However, when reported by the doctor, coverage for the elastomeric infusion pump is determined according to individual or group customer benefits.

Position Units

No allowance will be made for position. If extenuating circumstances exist in connection with the position of a patient, the services may be appealed for consideration by medical review.

Up to and including four (4) additional modifying units may be allowed when the anesthesiologist requests additional units for general anesthesia for congenital cataract extraction.

It will be necessary for the provider to submit medical records and/or additional documentation to determine coverage in this situation.

Anesthesia Services Prior to Postponement of Surgery

The Plan uses the following guidelines to adjudicate claims for the administration of anesthesia prior to the postponement of surgery:

1. If surgery is cancelled because of the anesthesiologist's preoperative appraisal, reimbursement can be made on the basis of a consultation. (Coverage for consultations is determined according to individual or group customer benefits.)
2. When surgery is aborted after general or regional anesthesia induction has taken place, reimbursement is made on the basis of 3 basic units plus time units multiplied by the conversion factor.
3. If anesthesia is reported under an NOC/NOS code, the Plan will adjudicate claims for the administration of anesthesia prior to the postponement of surgery, according to policy guidelines.

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Anesthesia payment is determined by the base unit for the anesthesia code and one time unit per 15 minutes of anesthesia time if:

1. The physician personally performed the entire anesthesia service alone, **or**;
2. The physician is a teaching physician involved with one or two concurrent resident cases or in one resident case that is concurrent to another case paid under medical direction payment rules (i.e., a nurse anesthetist or anesthesiologists assistant case), **or**
3. The physician is continuously involved in a single case involving a student nurse anesthetist, **or**
4. If the physician is involved with a single case with a CRNA or an anesthesia assistant (AA), payment can be for the physician service and the CRNA (or AA) service in accordance with the medical direction payment policy, **or**
5. The physician and the CRNA (or AA) is involved in one anesthesia case and the services of each are found to be necessary. Documentation must be submitted by both the CRNA and the physician to support payment of the full fee for each of the two providers. The physician reports the “AA” modifier and the CRNA reports the “QZ” modifier for a non-necessary case.

Payment for Directed Anesthesia

Payment for the physician’s directed service is determined on the basis of fifty (50) percent of the allowance for the service performed by the physician alone. Direction occurs if the physician directs qualified individuals in two, three, or four concurrent cases and the physician performs the following activities:

1. Performs a pre-anesthetic examination and evaluation;
2. Prescribes the anesthesia plan;

3. Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence;
4. Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist;
5. Monitors the course of anesthesia administration at frequent intervals;
6. Remains physically present and available for immediate diagnosis and treatment of emergencies; and
7. Provides indicated-post-anesthesia care.

The physician must participate only in the most demanding procedures of the anesthesia plan, including if applicable, induction and emergence. Also, for directed services, the physician must document in the medical record he or she performed the pre-anesthetic examination and evaluation. Physicians must also document they provided indicated post-anesthesia care, were present during some portion of the anesthesia monitoring, and were present during the most demanding procedures, including induction and emergence, where indicated.

The physician can direct two, three, or four concurrent procedures involving qualified individuals, all of whom could be CRNAs, AAs, interns, residents or combinations of these individuals. The direction rules apply to cases involving student nurse anesthetists if the physician directs two concurrent cases, each of which involves a student nurse anesthetist, or the physician directs one case involving a student nurse anesthetist and another involving a CRNA, AA, intern, or resident.

A physician who is concurrently directing the administration of anesthesia to not more than four surgical patients cannot ordinarily be involved in performing additional services to other patients. However, addressing an emergency of short duration in the immediate area, administering an epidural or caudal anesthetic to ease labor pain, or periodic, rather than continuous, monitoring of an obstetrical patient does not substantially diminish the scope of control exercised by the physician in directing the administration of anesthesia to surgical patients. It does not constitute a separate service for the purpose of determining whether the direction criteria are met. Further, while directing concurrent anesthesia procedures, a physician may receive patients entering the operating suite for the next surgery, check or discharge patients in the recovery room, or handle scheduling matters without affecting fee schedule payment.

However, if the physician leaves the immediate area of the operating suite for other than short durations or devotes extensive time to an emergency case or is otherwise not available to respond to the immediate needs of the surgical patients, the physician's services to the surgical patients are supervisory in nature and reimbursement cannot be made.

Only three base units per procedure may be allowed when the anesthesiologist is involved in performing more than four procedures concurrently or is performing other services while directing the concurrent procedures. An additional time unit may be recognized if the physician can document that they were personally present at induction.

If anesthesiologists are in a group practice, one physician member may provide the pre-anesthesia examination and evaluation while another fulfills the other criteria. Similarly, one physician member of the group may provide post-anesthesia care while another member of the group performs the other component parts of the anesthesia service. However, the patient medical record must indicate the services were performed by physicians and identify the physicians who performed them.

Anesthesia Services Provided by a Qualified Anesthetist

Reimbursement will be made for directed services when only one service is supervised. The payment

amount for the physician service and the CRNA service is fifty (50) percent (for each service) of the allowance otherwise recognized had the service been furnished solely by the anesthesiologist. Modifier QX should be appended to the procedure code(s) in these cases. For more information, please refer to medical policy N-118: *Anesthesia Services Provided by a Qualified Anesthetist.*

Note: This section is not applicable to the West Virginia Region

Screening Colonoscopy

When a screening colonoscopy becomes a diagnostic colonoscopy, anesthesia services are reported with CPT code 00811 (Anesthesia for lower intestinal endoscopic procedures, endoscopy introduced distal to duodenum; not otherwise specified) and with the PT modifier.

Modifier PT – Colorectal cancer screening test; converted to diagnostic test or other procedure

Dental Anesthesia

The Plan uses the following guidelines from the American Dental Association (ADA) for reporting dental anesthesia services. For the initial 15 minutes of anesthesia services provided using the appropriate Common Dental Terminology (CDT) Code:

D9222 – for deep sedation/general anesthesia, initial 15 minutes.

D9239 – for intravenous moderate (conscious) sedation/analgesia, initial 15 minutes.

Note: Base unit values will apply only to the initial 15 mins of service. Submit as one unit.

Submit subsequent 15-minute increments of anesthesia services provided (after the initial 15 minutes) using the appropriate CDT code:

D9223 – for deep sedation/general anesthesia, each subsequent 15-minute increment

D9243 – for intravenous moderate (conscience) sedation/analgesia, each subsequent 15-minute increment.

Note: Please bill one unit for every 15 minutes of anesthesia time on a separate claim line.

Labor and Delivery *(Commercial Only)*

Anesthesia for Obstetrics services would focus on management of pregnant patients during labor, non-operative delivery, operative delivery, and selected aspects of postpartum care.

Commercial Applicable Codes:

01958 01960 01961 01962 01963 01965 01966 01967 01968 01969

Add-on codes are always performed in addition to the primary service or procedure and must never be reported as a standalone code on a separate claim. In situations where obstetrical anesthesia for planned vaginal delivery begins on one day and ends in caesarean delivery on the following day, the date of service for both codes (01967 and 01968) should be the date of delivery. Codes should not be reported on separate claims or span multiple dates of service. Add-on codes submitted with no primary code or a different date of service result in rejection and non-payment of the add-on code.

Physical Status Units *(Commercial Only)*

Patient physical status should be reported under the appropriate modifier (P1-P6).

Physical Status I (Modifier P1): *Units allowed = 0*

- This modifier represents a normally healthy patient. There is no organic, physiologic, biochemical, or psychiatric disturbance. The pathological process for which the operation is to be performed is localized and not conducive to systemic disturbance.

Physical Status II (Modifier P2): Units allowed = 0

- This modifier represents a patient with mild to moderate systemic disturbance caused either by the condition to be treated surgically or by other pathophysiologic processes.

Physical Status III (Modifier P3): *Units allowed = 1*

- This modifier represents a patient with severe systemic disease.

Physical Status IV (Modifier P4): Units allowed = 2

- This modifier represents a patient with severe systemic disorder already life threatening and not always correctable by operative procedures.

Physical Status V (Modifier P5): Units allowed = 3

- This modifier represents a moribund patient who has little chance of survival but is submitted to operation in desperation. This classification is rarely used.

Physical Status VI (Modifier P6): *Units allowed = 0*

ADDITIONAL BILLING INFORMATION AND GUIDELINES:

- Provider Communication issued 11.30.18

RELATED HIGHMARK POLICIES:

Refer to the following Medicare Advantage Medical Policies for additional information:

- N-118: Anesthesia Services Provided by a Qualified Anesthetist

Refer to the following Reimbursement Policies for additional information:

- RP-025: Implantation of Subcutaneous Intravascular Catheter
- RP-009: Modifiers 25, 59, XE, XP, XS and XU

REFERENCES:

- CMS Online Manual Publication: 100-04, Chapter 12, Section 50
- Current Procedural Terminology (CPT)
- National Uniform Billing committee

POLICY UPDATE HISTORY INFORMATION:

3 / 2018	Implementation
8 / 2019	Added Dental, Labor and Delivery
10 / 2019	Added additional verbiage related to Dental, Labor and Delivery
10 / 2021	Added NY region applicable to the policy with note for NY under Modifying Units section

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSIONS

Bulletin Number:	RP-033		
Subject:	Anesthesia Services		
Effective Date:	March 12, 2018	**End Date:**	
Issue Date:	July 6, 2021	**Revised Date:**	July 2021
Date Reviewed:	July 2021		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV** ☒	**DE**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV** ☒		
Applicable Claim Type	**UB**	☐	**1500** ☒		

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this Policy.

PURPOSE:

This policy is to provide direction on the Plan's reimbursement of anesthesia services.

REIMBURSEMENT GUIDELINES:

The following types of anesthesia qualify for reimbursement as anesthesia services:

1. Inhalation
2. Regional
    - Spinal (low spinal, saddle block)
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    - Nerve block (retrobulbar, brachial plexus block, etc.)
    - Field block
3. Intravenous
4. Rectal
5. Conscious sedation

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The basic value for anesthesia when multiple surgical procedures are performed is the basic value for the procedure with the highest unit value. Reimbursement is not allowed for the basic unit value of a second, third, etc., procedure.

Anesthesia time begins when the anesthesiologist or CRNA is first in attendance with the patient for the purpose of creating the anesthetic state. Anesthesia time ends when the anesthesiologist or CRNA is no longer in personal attendance; that is, when the patient may be safely placed under customary postoperative supervision. This time must be documented on the anesthesia record, but not on the claim.

Time must be indicated on all anesthesia claims. Report the actual time spent administering anesthesia as minutes on the claim in the "days or units" block. The Plan will convert total minutes to time units. A "time unit" is a measure of each fifteen (15) minute interval or the actual time reported. Time units are calculated by dividing the total minutes of anesthesia time reported by fifteen (15), rounding to one decimal place (e.g., total anesthesia time of 48 minutes divided by 15 equals 3.2 time units).

Note: Report units, not minutes for moderate (conscious) sedation.

Applicable codes: 01991 01992 A9270 J0670 J2001 J2795 S0020

Direction of Anesthesia Services

The amount for physician anesthesia services is based on allowable base and time units multiplied by an anesthesia conversion factor.

Concurrent directed anesthesia procedures are defined with regard to the maximum number of procedures that the physician is directing within the context of a single procedure.

Physicians must report the appropriate anesthesia modifier to denote whether the service was personally performed, directed, or supervised.

Specific anesthesia modifiers include:

AA - Anesthesia Services performed personally by the anesthesiologist

AD - Medical Supervision by a physician; more than 4 concurrent anesthesia procedures

G8 - Monitored anesthesia care (MAC) for deep complex complicated or markedly invasive surgical procedures

G9 - Monitored anesthesia care for patient who has a history of severe cardio-pulmonary condition

QK - Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals

QS - Monitored anesthesia care service

QX - CRNA service; with medical direction by a physician

QY - Medical direction of one certified registered nurse anesthetist by an anesthesiologist

QZ - CRNA service: without medical direction by a physician

Note: The QS modifier is for informational purposes. Providers must report actual anesthesia time on the claim.

Modifying Units for Anesthesia Services

Modifying units represent those circumstances that necessitate skills of a physician beyond those usually required.

Modifying circumstances representative of age, emergency, total body hypothermia, and controlled hypotension should be reported under codes 99100, 99116, 99135 and 99140. These procedures are not associated with numbers of units and they will be reimbursed at a flat fee.

Note: Medicare Advantage does not separately reimburse for codes 99100, 99116, 99135 or 99140.

Code 99100 (Age)

- Reimbursement may be allowed for patients under one (1) year of age, or 71 years of age or older.

Code 99140 (Emergency)

- Reimbursement may be made for any service reported as an "emergency," except for a normal vaginal delivery.

Other Modifying Codes

- Reimbursement may be allowed when the doctor requests either utilization of total body hypothermia (code 99116) or utilization of controlled hypotension (99135).

- This modifier represents a declared brain-dead patient whose organs are being removed for donor purposes. If the doctor reports physical status III, IV, or V, payment may be allowed for the units listed above. If the doctor does not report physical status, no additional units will be allowed.

Monitoring Services Performed in Conjunction with the Administration of Anesthesia

The reporting of anesthesia services is appropriate by or under the responsible supervision of a physician. These services may include but are not limited to general, regional, supplementation of local anesthesia, or other supportive services to afford the patient the anesthesia care deemed optimal by the anesthesiologist during any procedure.

If monitoring services are reported on the same day as anesthesia, and the charges are itemized, the Plan will combine the charges and reimburse only the anesthesia. Reimbursement for the anesthesia performed on the same date of service includes the allowance for these services and are not eligible as a separate and distinct service. A participating or network provider cannot separately bill the member for these services. If these services are independently performed, report the service with modifier 59.

The Plan considers pre-operative and post-operative visits part of the global anesthesia allowance.

Examples of monitoring procedures performed during the course of administering anesthesia or for purposes of intraoperative anesthesia management are:

- ECG/EKG monitoring
- Administration of fluids and/or blood

- Respiratory functions (i.e. oxygen saturation [oximetry], end-tidal CO2 monitoring [capnography], etc.)
- Temperature
- Blood Pressure
- Mass spectrometry (Commercial products only)

Note: Modifier 59 may be reported with a non-E/M service, to identify it as distinct or independent from other non-E/M services performed on the same day. When modifier 59 is reported, the patient medical record must support its use in accordance with CPT guidelines.

Applicable Codes:

36430 36440 36450 36455 36460 83789 93000 93005 93010 93040 93041 93042 94680 94681 94690 94726 94727 94728 94729 94750 94760 94761 94770

Medicare Advantage Applicable Codes:

36430 36440 93000 93005 93010 93040 93041 93042 94680 94681 94690 94760 94761 94770

Continuous Local Delivery of Analgesia to Operative Sites Using an Elastomeric Infusion Pump

Continuous infusion of an analgesic to operative wound sites is a technique for postoperative pain control for surgeries typically requiring oral or parenteral narcotics.

Local delivery of analgesia to operative sites is designed to reduce postoperative pain, while limiting systemic side effects of analgesia. Additional benefits include reduced need for oral narcotics, decreased incidence of breakthrough pain, and faster return to normal activities. Drug delivery can be regulated through the use of simple disposable elastomeric pumps filled with analgesics attached to a variety of catheters that provide continuous delivery of the drug to the surgical site. Catheters may contain multiple openings so that the drug seeps into the operative wound all along its length. Elastomeric infusion pumps are designed to deliver drugs for up to five days followed by removal of the catheter. Elastomeric pumps to deliver local analgesia have been used postoperatively for the following:

- Orthopedic procedures, such as repair of the anterior cruciate ligament
- Urology procedures, such as prostatectomy
- Plastic surgery procedures
- Obstetrical/gynecologic procedures, such as cesarean section
- Gastrointestinal surgery procedures, such as hemorrhoidectomy or gastric bypass
- Thoracic surgery procedures, such as thoracotomy
- Cardiovascular surgery procedures, such as sternotomy

Only elastomeric pumps and associated catheters that have received approval from the US Food and Drug Administration (FDA) are to be used.

Reimbursement for catheter insertion and removal to provide continuous delivery of a drug to a surgical site is included in the allowance for the surgery and therefore, is not eligible for separate reimbursement.

The elastomeric infusion pump (codes A4305 and A4306) is a supply most commonly reported as a facility expense. However, when reported by the doctor, coverage for the elastomeric infusion pump is determined according to individual or group customer benefits.

Position Units

No allowance will be made for position. If extenuating circumstances exist in connection with the position of a patient, the services may be appealed for consideration by medical review.

Up to and including four (4) additional modifying units may be allowed when the anesthesiologist requests additional units for general anesthesia for congenital cataract extraction.

It will be necessary for the provider to submit medical records and/or additional documentation to determine coverage in this situation.

Anesthesia Services Prior to Postponement of Surgery

The Plan uses the following guidelines to adjudicate claims for the administration of anesthesia prior to the postponement of surgery:

1. If surgery is cancelled because of the anesthesiologist's preoperative appraisal, reimbursement can be made on the basis of a consultation. (Coverage for consultations is determined according to individual or group customer benefits.)
2. When surgery is aborted after general or regional anesthesia induction has taken place, reimbursement is made on the basis of 3 basic units plus time units multiplied by the conversion factor.
3. If anesthesia is reported under an NOC/NOS code, the Plan will adjudicate claims for the administration of anesthesia prior to the postponement of surgery, according to policy guidelines.

Payment for Personally Performed Anesthesia

Anesthesia payment is determined by the base unit for the anesthesia code and one time unit per 15 minutes of anesthesia time if:

1. The physician personally performed the entire anesthesia service alone, **or**;
2. The physician is a teaching physician involved with one or two concurrent resident cases or in one resident case that is concurrent to another case paid under medical direction payment rules (i.e., a nurse anesthetist or anesthesiologists assistant case), **or**
3. The physician is continuously involved in a single case involving a student nurse anesthetist, **or**
4. If the physician is involved with a single case with a CRNA or an anesthesia assistant (AA), payment can be for the physician service and the CRNA (or AA) service in accordance with the medical direction payment policy, **or**
5. The physician and the CRNA (or AA) is involved in one anesthesia case and the services of each are found to be necessary. Documentation must be submitted by both the CRNA and the physician to support payment of the full fee for each of the two providers. The physician reports the “AA” modifier and the CRNA reports the “QZ” modifier for a non-necessary case.

Payment for Directed Anesthesia

Payment for the physician’s directed service is determined on the basis of fifty (50) percent of the allowance for the service performed by the physician alone. Direction occurs if the physician directs qualified individuals in two, three, or four concurrent cases and the physician performs the following activities:

1. Performs a pre-anesthetic examination and evaluation;
2. Prescribes the anesthesia plan;

3. Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence;
4. Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist;
5. Monitors the course of anesthesia administration at frequent intervals;
6. Remains physically present and available for immediate diagnosis and treatment of emergencies; and
7. Provides indicated-post-anesthesia care.

The physician must participate only in the most demanding procedures of the anesthesia plan, including if applicable, induction and emergence. Also, for directed services, the physician must document in the medical record he or she performed the pre-anesthetic examination and evaluation. Physicians must also document they provided indicated post-anesthesia care, were present during some portion of the anesthesia monitoring, and were present during the most demanding procedures, including induction and emergence, where indicated.

The physician can direct two, three, or four concurrent procedures involving qualified individuals, all of whom could be CRNAs, AAs, interns, residents or combinations of these individuals. The direction rules apply to cases involving student nurse anesthetists if the physician directs two concurrent cases, each of which involves a student nurse anesthetist, or the physician directs one case involving a student nurse anesthetist and another involving a CRNA, AA, intern, or resident.

A physician who is concurrently directing the administration of anesthesia to not more than four surgical patients cannot ordinarily be involved in performing additional services to other patients. However, addressing an emergency of short duration in the immediate area, administering an epidural or caudal anesthetic to ease labor pain, or periodic, rather than continuous, monitoring of an obstetrical patient does not substantially diminish the scope of control exercised by the physician in directing the administration of anesthesia to surgical patients. It does not constitute a separate service for the purpose of determining whether the direction criteria are met. Further, while directing concurrent anesthesia procedures, a physician may receive patients entering the operating suite for the next surgery, check or discharge patients in the recovery room, or handle scheduling matters without affecting fee schedule payment.

However, if the physician leaves the immediate area of the operating suite for other than short durations or devotes extensive time to an emergency case or is otherwise not available to respond to the immediate needs of the surgical patients, the physician's services to the surgical patients are supervisory in nature and reimbursement cannot be made.

Only three base units per procedure may be allowed when the anesthesiologist is involved in performing more than four procedures concurrently or is performing other services while directing the concurrent procedures. An additional time unit may be recognized if the physician can document that they were personally present at induction.

If anesthesiologists are in a group practice, one physician member may provide the pre-anesthesia examination and evaluation while another fulfills the other criteria. Similarly, one physician member of the group may provide post-anesthesia care while another member of the group performs the other component parts of the anesthesia service. However, the patient medical record must indicate the services were performed by physicians and identify the physicians who performed them.

Anesthesia Services Provided by a Qualified Anesthetist

Reimbursement will be made for directed services when only one service is supervised. The payment amount for the physician service and the CRNA service is fifty (50) percent (for each service) of the allowance otherwise recognized had the service been furnished solely by the anesthesiologist. Modifier QX should be appended to the procedure code(s) in these cases. For more information, please refer to medical policy N-118: *Anesthesia Services Provided by a Qualified Anesthetist.*

Note: This section is not applicable to the West Virginia Region.

Screening Colonoscopy

When a screening colonoscopy becomes a diagnostic colonoscopy, anesthesia services are reported with CPT code 00811 (Anesthesia for lower intestinal endoscopic procedures, endoscopy introduced distal to duodenum; not otherwise specified) and with the PT modifier.

Modifier PT – Colorectal cancer screening test; converted to diagnostic test or other procedure

Dental Anesthesia

The Plan uses the following guidelines from the American Dental Association (ADA) for reporting dental anesthesia services. For the initial 15 minutes of anesthesia services provided using the appropriate Common Dental Terminology (CDT) Code:

D9222 – for deep sedation/general anesthesia, initial 15 minutes.

D9239 – for intravenous moderate (conscious) sedation/analgesia, initial 15 minutes.

Note: Base unit values will apply only to the initial 15 mins of service. Submit as one unit.

Submit subsequent 15-minute increments of anesthesia services provided (after the initial 15 minutes) using the appropriate CDT code:

D9223 – for deep sedation/general anesthesia, each subsequent 15-minute increment

D9243 – for intravenous moderate (conscience) sedation/analgesia, each subsequent 15-minute increment.

Note: Please bill one unit for every 15 minutes of anesthesia time on a separate claim line.

Labor and Delivery *(Commercial Only)*

Anesthesia for Obstetrics services would focus on management of pregnant patients during labor, non-operative delivery, operative delivery, and selected aspects of postpartum care.

Commercial Applicable Codes:

01958 01960 01961 01962 01963 01965 01966 01967 01968 01969

Add-on codes are always performed in addition to the primary service or procedure and must never be reported as a standalone code on a separate claim. In situations where obstetrical anesthesia for planned vaginal delivery begins on one day and ends in caesarean delivery on the following day, the

date of service for both codes (01967 and 01968) should be the date of delivery. Codes should not be reported on separate claims or span multiple dates of service. Add-on codes submitted with no primary code or a different date of service result in rejection and non-payment of the add-on code.

Physical Status Units *(Commercial Only)*

Patient physical status should be reported under the appropriate modifier (P1-P6).

Physical Status I (Modifier P1): *Units allowed = 0*

- This modifier represents a normally healthy patient. There is no organic, physiologic, biochemical, or psychiatric disturbance. The pathological process for which the operation is to be performed is localized and not conducive to systemic disturbance.

Physical Status II (Modifier P2): Units allowed = 0

- This modifier represents a patient with mild to moderate systemic disturbance caused either by the condition to be treated surgically or by other pathophysiologic processes.

Physical Status III (Modifier P3): *Units allowed = 1*

- This modifier represents a patient with severe systemic disease.

Physical Status IV (Modifier P4): Units allowed = 2

- This modifier represents a patient with severe systemic disorder already life threatening and not always correctable by operative procedures.

Physical Status V (Modifier P5): Units allowed = 3

- This modifier represents a moribund patient who has little chance of survival but is submitted to operation in desperation. This classification is rarely used.

Physical Status VI (Modifier P6): Units allowed = 0

RELATED HIGHMARK POLICIES:

Refer to the following Medical Policies for additional information:

- Medical Policy N-118: Anesthesia Services Provided by a Qualified Anesthetist
- Provider Communication issued 11.30.18

Refer to the following Reimbursement Policies for additional information:

- Reimbursement Policy RP-025: Implantation of Subcutaneous Intravascular Catheter
- Reimbursement Policy RP-009: Modifiers 25, 59, XE, XP, XS and XU

REFERENCES:

- CMS Online Manual Publication: 100-04, Chapter 12, Section 50

- Current Procedural Terminology (CPT)
- National Uniform Billing committee

POLICY UPDATE HISTORY INFORMATION:

03 / 2018	Implementation
08 / 2019	Added Dental, Labor and Delivery
10 / 2019	Added additional verbiage related to Dental, Labor and Delivery
7 /2021	Added MA note under Modifying Units for Anesthesia Services section

Highmark Reimbursement Policy Bulletin

HIGHMARK.

HISTORY VERSIONS

Bulletin Number:	RP-033		
Subject:	Anesthesia Services		
Effective Date:	March 12, 2018	**End Date:**	
Issue Date:	October 1, 2019	**Revised Date:**	July 2019
Date Reviewed:	July 2019		
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV** ☒	**DE**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV** ☒		
Applicable Claim Type	**UB**	☐	**1500** ☒		

Reimbursement Policy designation of Professional or Facility application is based on how the provider is contracted with the Plan. This Policy supersedes direction provided in Bulletins prior to the effective date of this Policy.

PURPOSE:

This policy is to provide direction on the Plan's reimbursement of anesthesia services.

REIMBURSEMENT GUIDELINES:

The following types of anesthesia qualify for reimbursement as anesthesia services:

1. Inhalation
2. Regional
    - Spinal (low spinal, saddle block)
    - Epidural (caudal)
    - Nerve block (retrobulbar, brachial plexus block, etc.)
    - Field block
3. Intravenous
4. Rectal
5. Conscious sedation

Anesthesia for diagnostic or therapeutic nerve blocks and injections (codes 01991 and 01992) are eligible for reimbursement when the block or injection is performed by a different provider.

Local anesthesia (A9270), which is direct infiltration of the incision, wound, or lesion is not a covered service.

Reimbursement for anesthesia services is based on the use of relative value units, including base units, plus time units and eligible modifying units when appropriate, multiplied by a monetary conversion factor.

The basic value for anesthesia when multiple surgical procedures are performed is the basic value for the procedure with the highest unit value. Reimbursement is not allowed for the basic unit value of a second, third, etc., procedure.

Anesthesia time begins when the anesthesiologist or CRNA is first in attendance with the patient for the purpose of creating the anesthetic state. Anesthesia time ends when the anesthesiologist or CRNA is no longer in personal attendance; that is, when the patient may be safely placed under customary postoperative supervision. This time must be documented on the anesthesia record, but not on the claim.

Time must be indicated on all anesthesia claims. Report the actual time spent administering anesthesia as minutes on the claim in the "days or units" block. The Plan will convert total minutes to time units. A "time unit" is a measure of each fifteen (15) minute interval or the actual time reported. Time units are calculated by dividing the total minutes of anesthesia time reported by fifteen (15), rounding to one decimal place (e.g., total anesthesia time of 48 minutes divided by 15 equals 3.2 time units).

Note: Report units, not minutes for moderate (conscious) sedation.

Applicable codes: 01991 01992 A9270 J0670 J2001 J2795 S0020

Direction of Anesthesia Services

The amount for physician anesthesia services is based on allowable base and time units multiplied by an anesthesia conversion factor.

Concurrent directed anesthesia procedures are defined with regard to the maximum number of procedures that the physician is directing within the context of a single procedure.

Physicians must report the appropriate anesthesia modifier to denote whether the service was personally performed, directed, or supervised.

Specific anesthesia modifiers include:

AA - Anesthesia Services performed personally by the anesthesiologist

AD - Medical Supervision by a physician; more than 4 concurrent anesthesia procedures

G8 - Monitored anesthesia care (MAC) for deep complex complicated or markedly invasive surgical procedures

G9 - Monitored anesthesia care for patient who has a history of severe cardio-pulmonary condition

QK - Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals

QS - Monitored anesthesia care service

QX - CRNA service; with medical direction by a physician

QY - Medical direction of one certified registered nurse anesthetist by an anesthesiologist

QZ - CRNA service: without medical direction by a physician

Note: The QS modifier is for informational purposes. Providers must report actual anesthesia time on the claim.

Modifying Units for Anesthesia Services

Modifying units represent those circumstances that necessitate skills of a physician beyond those usually required.

Modifying circumstances representative of age, emergency, total body hypothermia, and controlled hypotension should be reported under codes 99100, 99116, 99135 and 99140. These procedures are not associated with numbers of units and they will be reimbursed at a flat fee.

Code 99100 (Age)

- Reimbursement may be allowed for patients under one (1) year of age, or 71 years of age or older.

Code 99140 (Emergency)

- Reimbursement may be made for any service reported as an "emergency," except for a normal vaginal delivery.

Other Modifying Codes

- Reimbursement may be allowed when the doctor requests either utilization of total body hypothermia (code 99116) or utilization of controlled hypotension (99135).

- This modifier represents a declared brain-dead patient whose organs are being removed for donor purposes. If the doctor reports physical status III, IV, or V, payment may be allowed for the units listed above. If the doctor does not report physical status, no additional units will be allowed.

Monitoring Services Performed in Conjunction with the Administration of Anesthesia

The reporting of anesthesia services is appropriate by or under the responsible supervision of a physician. These services may include but are not limited to general, regional, supplementation of local anesthesia, or other supportive services to afford the patient the anesthesia care deemed optimal by the anesthesiologist during any procedure.

If monitoring services are reported on the same day as anesthesia, and the charges are itemized, the Plan will combine the charges and reimburse only the anesthesia. Reimbursement for the anesthesia performed on the same date of service includes the allowance for these services and are not eligible as a separate and distinct service. A participating or network provider cannot separately bill the member for these services. If these services are independently performed, report the service with modifier 59.

The Plan considers pre-operative and post-operative visits part of the global anesthesia allowance.

Examples of monitoring procedures performed during the course of administering anesthesia or for purposes of intraoperative anesthesia management are:

- ECG/EKG monitoring
- Administration of fluids and/or blood

- Respiratory functions (i.e. oxygen saturation [oximetry], end-tidal CO2 monitoring [capnography], etc.)
- Temperature
- Blood Pressure
- Mass spectrometry (Commercial products only)

Note: Modifier 59 may be reported with a non-E/M service, to identify it as distinct or independent from other non-E/M services performed on the same day. When modifier 59 is reported, the patient medical record must support its use in accordance with CPT guidelines.

Applicable Codes:

36430 36440 36450 36455 36460 83789 93000 93005 93010 93040 93041 93042 94680 94681 94690 94726 94727 94728 94729 94750 94760 94761 94770

Medicare Advantage Applicable Codes:

36430 36440 93000 93005 93010 93040 93041 93042 94680 94681 94690 94760 94761 94770

Continuous Local Delivery of Analgesia to Operative Sites Using an Elastomeric Infusion Pump

Continuous infusion of an analgesic to operative wound sites is a technique for postoperative pain control for surgeries typically requiring oral or parenteral narcotics.

Local delivery of analgesia to operative sites is designed to reduce postoperative pain, while limiting systemic side effects of analgesia. Additional benefits include reduced need for oral narcotics, decreased incidence of breakthrough pain, and faster return to normal activities. Drug delivery can be regulated through the use of simple disposable elastomeric pumps filled with analgesics attached to a variety of catheters that provide continuous delivery of the drug to the surgical site. Catheters may contain multiple openings so that the drug seeps into the operative wound all along its length. Elastomeric infusion pumps are designed to deliver drugs for up to five days followed by removal of the catheter. Elastomeric pumps to deliver local analgesia have been used postoperatively for the following:

- Orthopedic procedures, such as repair of the anterior cruciate ligament
- Urology procedures, such as prostatectomy
- Plastic surgery procedures
- Obstetrical/gynecologic procedures, such as cesarean section
- Gastrointestinal surgery procedures, such as hemorrhoidectomy or gastric bypass
- Thoracic surgery procedures, such as thoracotomy
- Cardiovascular surgery procedures, such as sternotomy

Only elastomeric pumps and associated catheters that have received approval from the US Food and Drug Administration (FDA) are to be used.

Reimbursement for catheter insertion and removal to provide continuous delivery of a drug to a surgical site is included in the allowance for the surgery and therefore, is not eligible for separate reimbursement.

The elastomeric infusion pump (codes A4305 and A4306) is a supply most commonly reported as a facility expense. However, when reported by the doctor, coverage for the elastomeric infusion pump is determined according to individual or group customer benefits.

Position Units

No allowance will be made for position. If extenuating circumstances exist in connection with the position of a patient, the services may be appealed for consideration by medical review.

Up to and including four (4) additional modifying units may be allowed when the anesthesiologist requests additional units for general anesthesia for congenital cataract extraction.

It will be necessary for the provider to submit medical records and/or additional documentation to determine coverage in this situation.

Anesthesia Services Prior to Postponement of Surgery

The Plan uses the following guidelines to adjudicate claims for the administration of anesthesia prior to the postponement of surgery:

1. If surgery is cancelled because of the anesthesiologist's preoperative appraisal, reimbursement can be made on the basis of a consultation. (Coverage for consultations is determined according to individual or group customer benefits.)
2. When surgery is aborted after general or regional anesthesia induction has taken place, reimbursement is made on the basis of 3 basic units plus time units multiplied by the conversion factor.
3. If anesthesia is reported under an NOC/NOS code, the Plan will adjudicate claims for the administration of anesthesia prior to the postponement of surgery, according to policy guidelines.

Payment for Personally Performed Anesthesia

Anesthesia payment is determined by the base unit for the anesthesia code and one time unit per 15 minutes of anesthesia time if:

1. The physician personally performed the entire anesthesia service alone, **or**;
2. The physician is a teaching physician involved with one or two concurrent resident cases or in one resident case that is concurrent to another case paid under medical direction payment rules (i.e., a nurse anesthetist or anesthesiologists assistant case), **or**
3. The physician is continuously involved in a single case involving a student nurse anesthetist, **or**
4. If the physician is involved with a single case with a CRNA or an anesthesia assistant (AA), payment can be for the physician service and the CRNA (or AA) service in accordance with the medical direction payment policy, **or**
5. The physician and the CRNA (or AA) is involved in one anesthesia case and the services of each are found to be necessary. Documentation must be submitted by both the CRNA and the physician

to support payment of the full fee for each of the two providers. The physician reports the "AA" modifier and the CRNA reports the "QZ" modifier for a non-necessary case.

Payment for Directed Anesthesia

Payment for the physician's directed service is determined on the basis of fifty (50) percent of the allowance for the service performed by the physician alone. Direction occurs if the physician directs qualified individuals in two, three, or four concurrent cases and the physician performs the following activities:

1. Performs a pre-anesthetic examination and evaluation;
2. Prescribes the anesthesia plan;
3. Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence;
4. Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist;
5. Monitors the course of anesthesia administration at frequent intervals;
6. Remains physically present and available for immediate diagnosis and treatment of emergencies; and
7. Provides indicated-post-anesthesia care.

The physician must participate only in the most demanding procedures of the anesthesia plan, including if applicable, induction and emergence. Also, for directed services, the physician must document in the medical record he or she performed the pre-anesthetic examination and evaluation. Physicians must also document they provided indicated post-anesthesia care, were present during some portion of the anesthesia monitoring, and were present during the most demanding procedures, including induction and emergence, where indicated.

The physician can direct two, three, or four concurrent procedures involving qualified individuals, all of whom could be CRNAs, AAs, interns, residents or combinations of these individuals. The direction rules apply to cases involving student nurse anesthetists if the physician directs two concurrent cases, each of which involves a student nurse anesthetist, or the physician directs one case involving a student nurse anesthetist and another involving a CRNA, AA, intern, or resident.

A physician who is concurrently directing the administration of anesthesia to not more than four surgical patients cannot ordinarily be involved in performing additional services to other patients. However, addressing an emergency of short duration in the immediate area, administering an epidural or caudal anesthetic to ease labor pain, or periodic, rather than continuous, monitoring of an obstetrical patient does not substantially diminish the scope of control exercised by the physician in directing the administration of anesthesia to surgical patients. It does not constitute a separate service for the purpose of determining whether the direction criteria are met. Further, while directing concurrent anesthesia procedures, a physician may receive patients entering the operating suite for the next surgery, check or discharge patients in the recovery room, or handle scheduling matters without affecting fee schedule payment.

However, if the physician leaves the immediate area of the operating suite for other than short durations or devotes extensive time to an emergency case or is otherwise not available to respond to the immediate

needs of the surgical patients, the physician's services to the surgical patients are supervisory in nature and reimbursement cannot be made.

Only three base units per procedure may be allowed when the anesthesiologist is involved in performing more than four procedures concurrently or is performing other services while directing the concurrent procedures. An additional time unit may be recognized if the physician can document that they were personally present at induction.

If anesthesiologists are in a group practice, one physician member may provide the pre-anesthesia examination and evaluation while another fulfills the other criteria. Similarly, one physician member of the group may provide post-anesthesia care while another member of the group performs the other component parts of the anesthesia service. However, the patient medical record must indicate the services were performed by physicians and identify the physicians who performed them.

Anesthesia Services Provided by a Qualified Anesthetist

Reimbursement will be made for directed services when only one service is supervised. The payment amount for the physician service and the CRNA service is fifty (50) percent (for each service) of the allowance otherwise recognized had the service been furnished solely by the anesthesiologist. Modifier QX should be appended to the procedure code(s) in these cases. For more information, please refer to medical policy N-118: *Anesthesia Services Provided by a Qualified Anesthetist.*

NOTE: This section is not applicable to the West Virginia Region

Screening Colonoscopy

When a screening colonoscopy becomes a diagnostic colonoscopy, anesthesia services are reported with CPT code 00811 (Anesthesia for lower intestinal endoscopic procedures, endoscopy introduced distal to duodenum; not otherwise specified) and with the PT modifier.

Modifier PT – Colorectal cancer screening test; converted to diagnostic test or other procedure

Dental Anesthesia

The Plan uses the following guidelines from the American Dental Association (ADA) for reporting dental anesthesia services. For the initial 15 minutes of anesthesia services provided using the appropriate Common Dental Terminology (CDT) Code:

D9222 – for deep sedation/general anesthesia, initial 15 minutes.

D9239 – for intravenous moderate (conscious) sedation/analgesia, initial 15 minutes.

NOTE: Base unit values will apply only to the initial 15 mins of service. Submit as one unit.

Submit subsequent 15-minute increments of anesthesia services provided (after the initial 15 minutes) using the appropriate CDT code:

D9223 – for deep sedation/general anesthesia, each subsequent 15-minute increment

D9243 – for intravenous moderate (conscience) sedation/analgesia, each subsequent 15-minute increment.

NOTE: Please bill one unit for every 15 minutes of anesthesia time on a separate claim line.

Labor and Delivery *(Commercial Only)*

Anesthesia for Obstetrics services would focus on management of pregnant patients during labor, non-operative delivery, operative delivery, and selected aspects of postpartum care.

Commercial Applicable Codes:

01958 01960 01961 01962 01963 01965 01966 01967 01968 01969

Add-on codes are always performed in addition to the primary service or procedure and must never be reported as a standalone code on a separate claim. In situations where obstetrical anesthesia for planned vaginal delivery begins on one day and ends in caesarean delivery on the following day, the date of service for both codes (01967 and 01968) should be the date of delivery. Codes should not be reported on separate claims or span multiple dates of service. Add-on codes submitted with no primary code or a different date of service result in rejection and non-payment of the add-on code.

Physical Status Units *(Commercial Only)*

Patient physical status should be reported under the appropriate modifier (P1-P6).

Physical Status I (Modifier P1): Units allowed = 0

- This modifier represents a normally healthy patient. There is no organic, physiologic, biochemical, or psychiatric disturbance. The pathological process for which the operation is to be performed is localized and not conducive to systemic disturbance.

Physical Status II (Modifier P2): Units allowed = 0

- This modifier represents a patient with mild to moderate systemic disturbance caused either by the condition to be treated surgically or by other pathophysiologic processes.

Physical Status III (Modifier P3): Units allowed = 1

- This modifier represents a patient with severe systemic disease.

Physical Status IV (Modifier P4): Units allowed = 2

- This modifier represents a patient with severe systemic disorder already life threatening and not always correctable by operative procedures.

Physical Status V (Modifier P5): Units allowed = 3

- This modifier represents a moribund patient who has little chance of survival but is submitted to operation in desperation. This classification is rarely used.

Physical Status VI (Modifier P6): Units allowed = 0

RELATED HIGHMARK POLICIES:

Refer to the following Medical Policies for additional information:

- Medical Policy N-118: Anesthesia Services Provided by a Qualified Anesthetist
- Provider Communication issued 11.30.18

Refer to the following Reimbursement Policies for additional information:

- Reimbursement Policy RP-025: Implantation of Subcutaneous Intravascular Catheter
- Reimbursement Policy RP-009: Modifiers 25, 59, XE, XP, XS and XU

REFERENCES:

CMS Online Manual Publication: 100-04, Chapter 12, Section 50
Current Procedural Terminology (CPT)
National Uniform Billing committee

POLICY UPDATE HISTORY INFORMATION:

03 / 2018	Implementation
08 / 2019	Added Dental, Labor and Delivery
10 / 2019	Added additional verbiage related to Dental, Labor and Delivery

Highmark Reimbursement Policy Bulletin

Bulletin Number:	RP-033		
Subject:	Anesthesia Services		
Effective Date:	March 12, 2018	**End Date:**	
Issue Date:	March 12, 2018	**Revised Date:**	
Source:	Reimbursement Policy		

Applicable Commercial Market	**PA**	☒	**WV** ☒	**DE**	☒
Applicable Medicare Advantage Market	**PA**	☒	**WV** ☒		
Applicable Claim Type	**UB**	☐	**1500** ☒		

Reimbursement Policy designation of Professional or Facility application is respective to how the provider is contracted with The Plan. Provider contractual agreement terms in direct conflict with this Reimbursement Policy may supersede this Policy's direction and regional applicability.

PURPOSE: This policy is to provide direction on The Plan's reimbursement of anesthesia services.

REIMBURSEMENT GUIDELINES:

The following types of anesthesia qualify for reimbursement as anesthesia services:

1. Inhalation
2. Regional
    - Spinal (low spinal, saddle block)
    - Epidural (caudal)
    - Nerve block (retrobulbar, brachial plexus block, etc.)
    - Field block
3. Intravenous
4. Rectal
5. Conscious sedation

Anesthesia for diagnostic or therapeutic nerve blocks and injections (codes 01991 and 01992) is eligible for reimbursement when the block or injection is performed by a different provider.

Local anesthesia (A9270), which is direct infiltration of the incision, wound, or lesion is not a covered service.

Reimbursement for anesthesia services is based on the use of relative value units, including base units, plus time units and eligible modifying units when appropriate, multiplied by a monetary conversion factor.

The basic value for anesthesia when multiple surgical procedures are performed is the basic value for the procedure with the highest unit value. Reimbursement is not allowed for the basic unit value of a second, third, etc., procedure.

Anesthesia time begins when the anesthesiologist or CRNA is first in attendance with the patient for the purpose of creating the anesthetic state. Anesthesia time ends when the anesthesiologist or CRNA is no longer in personal attendance; that is, when the patient may be safely placed under customary postoperative supervision. This time must be documented on the anesthesia record, but not on the claim.

Time must be indicated on all anesthesia claims. Report the actual time spent administering anesthesia as minutes on the claim in the "days or units" block. The Plan will convert total minutes to time units. A "time unit" is a measure of each fifteen (15) minute interval or the actual time reported. Time units are calculated by dividing the total minutes of anesthesia time reported by fifteen (15), rounding to one decimal place (e.g., total anesthesia time of 48 minutes divided by 15 equals 3.2 time units).

Note: Report units, not minutes for moderate (conscious) sedation.

Applicable codes: 01991 01992 A9270 J0670 J2001 J2795 S0020

Modifying Units for Anesthesia Services

Modifying units represent those circumstances that necessitate skills of a physician beyond those usually required.

Modifying circumstances representative of age, emergency, total body hypothermia, and controlled hypotension should be reported under codes 99100, 99116, 99135 and 99140. These procedures are not associated with numbers of units and they will be reimbursed at a flat fee.

Code 99100 (Age)

- Reimbursement may be allowed for patients under one (1) year of age, or 71 years of age or older.

Code 99140 (Emergency)

- Reimbursement may be made for any service reported as an "emergency," except for a normal vaginal delivery.

Other Modifying Codes

- Reimbursement may be allowed when the doctor requests either utilization of total body hypothermia (code 99116) or utilization of controlled hypotension (99135).

Physical Status Units

Patient physical status should be reported under the appropriate modifier (P1-P6).

Physical Status I (Modifier P1): *Units allowed = 0*

- This modifier represents a normally healthy patient. There is no organic, physiologic, biochemical, or psychiatric disturbance. The pathological process for which the operation is to be performed is localized and not conducive to systemic disturbance.

Physical Status II (Modifier P2): Units allowed = 0

- This modifier represents a patient with mild to moderate systemic disturbance caused either by the condition to be treated surgically or by other pathophysiologic processes.

Physical Status III (Modifier P3): Units allowed = 1

- This modifier represents a patient with severe systemic disease.

Physical Status IV (Modifier P4): Units allowed = 2

- This modifier represents a patient with severe systemic disorder already life threatening and not always correctable by operative procedures.

Physical Status V (Modifier P5): Units allowed = 3

- This modifier represents a moribund patient who has little chance of survival but is submitted to operation in desperation. This classification is rarely used.

Physical Status VI (Modifier P6): Units allowed = 0

- This modifier represents a declared brain-dead patient whose organs are being removed for donor purposes. If the doctor reports physical status III, IV, or V, payment may be allowed for the units listed above. If the doctor does not report physical status, no additional units will be allowed.

Position Units

No allowance will be made for position. If extenuating circumstances exist in connection with the position of a patient, the services may be appealed for consideration by medical review.

Up to and including four (4) additional modifying units may be allowed when the anesthesiologist requests additional units for general anesthesia for congenital cataract extraction.

It will be necessary for the provider to submit medical records and/or additional documentation to determine coverage in this situation.

Anesthesia Services Prior to Postponement of Surgery

The Plan uses the following guidelines to adjudicate claims for the administration of anesthesia prior to the postponement of surgery:

1. If surgery is cancelled because of the anesthesiologist's preoperative appraisal, reimbursement can be made on the basis of a consultation. (Coverage for consultations is determined according to individual or group customer benefits.)
2. When surgery is aborted after general or regional anesthesia induction has taken place, reimbursement is made on the basis of 3 basic units plus time units multiplied by the conversion factor.
3. If anesthesia is reported under an NOC/NOS code, the Plan will adjudicate claims for the administration of anesthesia prior to the postponement of surgery, according to policy guidelines.

Continuous Local Delivery of Analgesia to Operative Sites Using an Elastomeric Infusion Pump

Continuous infusion of an analgesic to operative wound sites is a technique for postoperative pain control for surgeries typically requiring oral or parenteral narcotics for pain control.

Local delivery of analgesia to operative sites is designed to reduce postoperative pain, while limiting systemic side effects of analgesia. Additional benefits include reduced need for oral narcotics, decreased incidence of breakthrough pain, and faster return to normal activities. Drug delivery can be regulated through the use of simple disposable elastomeric pumps filled with analgesics attached to a variety of catheters that provide continuous delivery of the drug to the surgical site. Catheters may contain multiple openings so that the drug seeps into the operative wound all along its length. Elastomeric infusion pumps are designed to deliver drugs for up to five days followed by removal of the catheter. Elastomeric pumps to deliver local analgesia have been used postoperatively for the following:

- Orthopedic procedures, such as repair of the anterior cruciate ligament
- Urology procedures, such as prostatectomy
- Plastic surgery procedures
- Obstetrical/gynecologic procedures, such as cesarean section
- Gastrointestinal surgery procedures, such as hemorrhoidectomy or gastric bypass
- Thoracic surgery procedures, such as thoracotomy
- Cardiovascular surgery procedures, such as sternotomy

Only elastomeric pumps and associated catheters that have received approval from the US Food and Drug Administration (FDA) are to be used.

Reimbursement for catheter insertion and removal to provide continuous delivery of a drug to a surgical site is included in the allowance for the surgery and therefore, is not eligible for separate reimbursement.

The elastomeric infusion pump (codes A4305 and A4306) is a supply most commonly reported as a facility expense. However, when reported by the doctor, coverage for the elastomeric infusion pump is determined according to individual or group customer benefits.

Monitoring Services Performed in Conjunction with the Administration of Anesthesia

The reporting of anesthesia services is appropriate by or under the responsible supervision of a physician. These services may include but are not limited to general, regional, supplementation of local anesthesia, or other supportive services in order to afford the patient the anesthesia care deemed optimal by the anesthesiologist during any procedure.

If monitoring services are reported on the same day as anesthesia, and the charges are itemized, the Plan will combine the charges and reimburse only the anesthesia. Reimbursement for the anesthesia performed on the same date of service includes the allowance for these services and are not eligible as a separate and distinct service. A participating or network provider cannot bill the member separately for these services. If these services are performed independently, report the service with modifier 59.

The Plan considers pre-operative and post-operative visits part of the global anesthesia allowance.

Examples of monitoring procedures performed during the course of administering anesthesia or for purposes of intraoperative anesthesia management are:

- ECG/EKG monitoring
- Administration of fluids and/or blood

- Respiratory functions (i.e. oxygen saturation [oximetry], end-tidal CO2 monitoring [capnography], etc.)
- Temperature
- Blood Pressure
- Mass spectrometry (Commercial products only)

Note: Modifier 59 may be reported with a non-E/M service, to identify it as distinct or independent from other non-E/M services performed on the same day. When modifier 59 is reported, the patient medical record must support its use in accordance with CPT guidelines.

Applicable Codes:

36430 36440 36450 36455 36460 83789 93000 93005 93010 93040 93041 93042 94680 94681 94690 94726 94727 94728 94729 94750 94760 94761 94770

Medicare Advantage Applicable Codes:

36430 36440 93000 93005 93010 93040 93041 93042 94680 94681 94690 94760 94761 94770

Direction of Anesthesia Services

The amount for physician anesthesia services is based on allowable base and time units multiplied by an anesthesia conversion factor.

Concurrent directed anesthesia procedures are defined with regard to the maximum number of procedures that the physician is directing within the context of a single procedure.

Physicians must report the appropriate anesthesia modifier to denote whether the service was personally performed, directed, or supervised.

Specific anesthesia modifiers include:

AA - Anesthesia Services performed personally by the anesthesiologist

AD - Medical Supervision by a physician; more than 4 concurrent anesthesia procedures

G8 - Monitored anesthesia care (MAC) for deep complex complicated or markedly invasive surgical procedures

G9 - Monitored anesthesia care for patient who has a history of severe cardio-pulmonary condition

QK - Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals

QS - Monitored anesthesia care service

QX - CRNA service; with medical direction by a physician

QY - Medical direction of one certified registered nurse anesthetist by an anesthesiologist

QZ - CRNA service: without medical direction by a physician

Note: The QS modifier is for informational purposes. Providers must report actual anesthesia time on the claim.

Payment for Personally Performed Anesthesia

Anesthesia payment is determined by the base unit for the anesthesia code and one time unit per 15 minutes of anesthesia time if:

1. The physician personally performed the entire anesthesia service alone; **or**,
2. The physician is a teaching physician involved with one or two concurrent resident cases or in one resident case that is concurrent to another case paid under medical direction payment rules; i.e., a nurse anesthetist or anesthesiologists assistant case; **or**,
3. The physician is continuously involved in a single case involving a student nurse anesthetist; **or**,
4. If the physician is involved with a single case with a CRNA or an anesthesia assistant (AA), payment can be for the physician service and the CRNA (or AA) service in accordance with the medical direction payment policy; **or**
5. The physician and the CRNA (or AA) is involved in one anesthesia case and the services of each are found to be necessary. Documentation must be submitted by both the CRNA and the physician to support payment of the full fee for each of the two providers. The physician reports the "AA" modifier and the CRNA reports the "QZ" modifier for a non-necessary case.

Payment for Directed Anesthesia

Payment for the physician's directed service is determined on the basis of fifty (50) percent of the allowance for the service performed by the physician alone. Direction occurs if the physician directs qualified individuals in two, three, or four concurrent cases and the physician performs the following activities:

1. Performs a pre-anesthetic examination and evaluation;
2. Prescribes the anesthesia plan;
3. Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence;
4. Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist;
5. Monitors the course of anesthesia administration at frequent intervals;
6. Remains physically present and available for immediate diagnosis and treatment of emergencies; and
7. Provides indicated-post-anesthesia care.

The physician must participate only in the most demanding procedures of the anesthesia plan, including if applicable, induction and emergence. Also, for directed services, the physician must document in the medical record that he or she performed the pre-anesthetic examination and evaluation. Physicians must also document they provided indicated post-anesthesia care, were present during some portion of the anesthesia monitoring, and were present during the most demanding procedures, including induction and emergence, where indicated.

The physician can direct two, three, or four concurrent procedures involving qualified individuals, all of whom could be CRNAs, AAs, interns, residents or combinations of these individuals. The direction rules apply to cases involving student nurse anesthetists if the physician directs two concurrent cases, each of which involves a student nurse anesthetist, or the physician directs one case involving a student nurse anesthetist and another involving a CRNA, AA, intern, or resident.

A physician who is concurrently directing the administration of anesthesia to not more than four surgical patients cannot ordinarily be involved in performing additional services to other patients. However, addressing an emergency of short duration in the immediate area, administering an epidural or caudal

anesthetic to ease labor pain, or periodic, rather than continuous, monitoring of an obstetrical patient does not substantially diminish the scope of control exercised by the physician in directing the administration of anesthesia to surgical patients. It does not constitute a separate service for the purpose of determining whether the direction criteria are met. Further, while directing concurrent anesthesia procedures, a physician may receive patients entering the operating suite for the next surgery, check or discharge patients in the recovery room, or handle scheduling matters without affecting fee schedule payment.

However, if the physician leaves the immediate area of the operating suite for other than short durations or devotes extensive time to an emergency case or is otherwise not available to respond to the immediate needs of the surgical patients, the physician's services to the surgical patients are supervisory in nature and reimbursement cannot be made.

Only three base units per procedure may be allowed when the anesthesiologist is involved in performing more than four procedures concurrently or is performing other services while directing the concurrent procedures. An additional time unit may be recognized if the physician can document that they were personally present at induction.

If anesthesiologists are in a group practice, one physician member may provide the pre-anesthesia examination and evaluation while another fulfills the other criteria. Similarly, one physician member of the group may provide post-anesthesia care while another member of the group performs the other component parts of the anesthesia service. However, the patient medical record must indicate that the services were performed by physicians and identify the physicians who performed them.

Anesthesia Services Provided by a Qualified Anesthetist

Reimbursement will be made for directed services when only one service is supervised. The payment amount for the physician service and the CRNA service is fifty (50) percent (for each service) of the allowance otherwise recognized had the service been furnished solely by the anesthesiologist. Modifier QX should be appended to the procedure code(s) in these cases. For more information, please refer to medical policy N-118: Anesthesia Services Provided by a Qualified Anesthetist.

RELATED HIGHMARK POLICIES:

Refer to the following Medical Policies for additional information:

- Medical Policy N-118: Anesthesia Services Provided by a Qualified Anesthetist

Refer to the following Reimbursement Policies for additional information:

- Reimbursement Policy RP-025: Implantation of Subcutaneous Intravascular Catheter
- Reimbursement Policy RP-009: Modifiers 25, 59, XE, XP, XS and XU

REFERENCES:

CMS Online Manual Publication: 100-04, Chapter 12, Section 50

Current Procedural Terminology (CPT)