Reimbursement Policy

Anesthesia Services

REIMBURSEMENT POLICY NUMBER: 26

Effective Date: 12/1/2025

Last Review Date: 9/2025

Next Annual Review: 9/2026

INSTRUCTIONS FOR USE: Company reimbursement policies serve as guidance for the administration of plan benefits. Reimbursement policies do not constitute medical advice nor a guarantee of coverage. Company reimbursement policies are reviewed annually. The Companies reserve the right to determine the application of reimbursement policies and make revisions to reimbursement policies at any time. The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Reimbursement Policy will be resolved in favor of the coverage agreement.

SCOPE AND APPLICATION

Provider Type:

☒ Participating Providers

☒ Non-Participating Providers

Plan Product:

☒ Commercial

☒ Medicare

☒ Medicaid/Oregon Health Plan (OHP)

POLICY STATEMENT

NOTES:

- The policy applies to all lines of business, except when otherwise indicated.
- Provider contract language and payment methodology may vary.

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as "Company" and collectively as "Companies").

GENERAL

I. Reimbursement for anesthesia services is made in accordance with the current American Society of Anesthesiologist (ASA) guidelines for CPT defined codes 00100 through 01999, in addition to any appropriate anesthesia payment modifiers.

II. For **non-obstetric** anesthesia, the fee schedule payment includes base unit and one time unit for each 15 minutes of anesthesia time, plus any modifying units. *(For **obstetric** anesthesia reimbursement [e.g., 01967], see Criterion IX below.)*

A. *Time Units:

i. Anesthesia time = 1 unit / 15 minutes.
   1. Providers should report the **total minutes of anesthesia time in the "units" column** on the claim form. While start and end times may be included as well, this information is not required for claim adjudication.
   2. "Anesthesia time" is the time in minutes during which the anesthesia provider is both furnishing continuous anesthesia care to a patient **and** is physically present with the patient. No reimbursement is provided for any type of "standby" or "monitoring" service without direct hands-on patient contact, even when required by the hospital.
   3. Formula: ASA Base units + time units x conversion factor

ii. Monitored anesthesia = 1 unit / 15 minutes.

III. One anesthesia provider at a time shall be reimbursed per patient, **except** for supervised anesthesia services by a CRNA under the medical direction of a physician **or** obstetric anesthesia where care was transferred from one anesthesiologist to another during the course of an obstetric encounter due to extensive time.

IV. Anesthesia HCPCS/CPT codes include all services integral to the anesthesia procedure (e.g., preparation, monitoring, intra-operative care, and post-operative care). Services considered an integral part of that anesthesia service are **not eligible for separate reimbursement**. The Plan follows NCCI guidelines regarding what services are considered integral (included in the base value) and which service may be reported separately. *(See below for integral services information.)*

V. For **facilities**, reimbursement for the control or management of pain in the immediate postoperative period is **packaged into payment for the surgical or anesthetic procedure**, regardless of the method by which the care provider, including the anesthesiologist, decides to manage pain. *(See below for more information regarding facilities billing for post-operative pain control.)*

Anesthesia Reimbursement Rates

VI. Reimbursement for anesthesia is based on whether or not the anesthesiologist (physician) performed all anesthesia services alone, and/or if other qualified individuals (e.g., CRNAs, anesthesiologists' assistants, interns, residents, or a combination of these individuals) were involved in the patient's anesthesia care or if other concurrent cases

were also being managed during this time. It is essential that anesthesia services are coded correctly, with appropriate modifiers, to ensure accurate reimbursement rates are applied. *(See "Anesthesia Payment Modifiers" below)*

A. **Modifier AA:** Provider reimbursed **100%** of the anesthesia service allowance.
B. **Modifier AD:** The anesthesiologist will be allowed three (3) base units and **no** time units for procedures billed with modifier AD, **except** for the following scenarios:

    1. No payment is allowed for code 01953 billed with modifier AD.
    2. One (1) time unit may be allowed on appeal for codes billed with modifier AD ***if*** the anesthesiologist was present at induction and documentation supports this.

C. **Modifier QK:** Each provider reimbursed **50%** of the anesthesia service allowance.
D. **Modifier QX:** Each provider reimbursed **50%** of the anesthesia service allowance.
E. **Modifier QY:** Each provider reimbursed **50%** of the anesthesia service allowance.
F. **Modifier QZ:** CRNA provider reimbursed **100%** of the anesthesia service allowance.

MISCELLAEOUS ANESTHESIA PAYMENT-RELATED INFORMATION

Multiple Anesthesia Procedures

VII. Reimbursement for multiple anesthesia procedures may be made based on:

A. The base unit of the anesthesia procedure with the highest base unit value **and**
B. Time units based on the actual total anesthesia time of the multiple procedures.

Obstetric Anesthesia

VIII. For **non-Medicaid** Plan Members, continuous obstetric anesthesia during labor and delivery may be reimbursed using base units + time units (insertion, management of adverse events, delivery, and removal), up to a maximum of 480 minutes. **Time will be allowed during the period when anesthesiologist is in attendance. Continuous obstetrical epidural equals time in attendance with the patient, and documentation must include the time and the service rendered.** Medical records must include documentation showing time and services performed. Documentation may be submitted for reconsideration of additional reimbursement for time reported in excess of 480 minutes. *(See section for "Obstetric Anesthesia Codes" below) (For **Medicaid/OHP** Plan members, see Oregon Administrative Rule (OAR) 410-130-0368 for neuraxial labor analgesia/anesthesia (code 01967) reimbursement.)*

Physical Status Modifiers (P0-P6)

NOTE: *Physical status modifiers are appropriate to use on anesthesia service/procedure CPT codes 00100 through 01999.*

IX. Physical status modifiers are **not** recognized for **Medicare or Medicaid** members and therefore, the Plan will not reimburse additional unit value(s) for anesthesia physical status modifiers for these Plan members.

X. Physical status modifiers may be recognized for **lines of business other than** Medicare and OHP as follows, and additional time unit payment may be allowed. *(See Billing Guidelines below for more information.)*

G. Physical Status Modifier 1 (P1): **No** additional time units.
H. Physical Status Modifier 2 (P2): **No** additional time units.
I. Physical Status Modifier 3 (P3): **One** additional time units.
J. Physical Status Modifier 4 (P4): **Two** additional time units.
K. Physical Status Modifier 5 (P5): **Three** additional time units.
L. Physical Status Modifier 6 (P6): **No** additional time units.

XI. **Inappropriate** use of physical status modifiers includes, but may not be limited to, the following scenarios:

A. Use on CPT codes **other than** 00100 through 01999.
B. Using one of these modifiers for a situation other than the one described by the modifier descriptor.

Qualifying Circumstances

XII. Qualifying circumstances (CPT codes 99100, 99116, 99135, and 99140) are **not** recognized and therefore, **are not eligible for reimbursement** for **any** line of business.

Monitored Anesthesia

XIII. Monitored anesthesia may be reimbursed the same as general or regional anesthetic, and risk factors may also be allowed, with the following exceptional circumstances:

A. For **Medicare Advantage** members, either 00811-PT or 00812 may be used. When screening colonoscopy is converted to diagnostic colonoscopy, CMS advises anesthesia providers to add modifier -PT to the anesthesia code for diagnostic colonoscopy (CPT code 00811). Therefore, the Plan allows CPT code 00811-PT for monitored anesthesia for Medicare members **only**.
B. For **Commercial and OHP** members, the Plan follows CPT guidelines, which state CPT code 00812 is used for screening colonoscopy, regardless of findings. *(This option may also be used for Medicare members at the provider's discretion.)*

Field Avoidance

XIV. Additional payment for field avoidance **may be separately reimbursable** subject to the following:

A. The base value is <5 units (additional units up to the maximum base value of 5 may be allowed to account for extra work related to patient airway access) *and* **at least one** of the following:
    i. The procedure is performed around the head, neck, or shoulder girdle; **and/or**
    ii. The procedure requires a position other than supine.

XV. Separate reimbursement for field avoidance is **not allowed** for procedures with a base value ≥ 5 units.

NOTE: *There is no modifier that identifies field avoidance. Reimbursement requires review, and providers will need to request a review with supporting documentation.*

Anesthesia Consultations

XVI. Anesthesia consultations **may be separately reimbursable** if care is initiated and/or recommended as a result of the consult.

XVII. Consultations are **not separately reimbursable** if performed as a pre-anesthesia evaluation in preparation for a surgical procedure. This service is included in the base rate and anesthesiologists may **not** bill additional fees for this service.

Ventilation Set Up and Assessment

XVIII. Ventilation set up and assessment **may be separately reimbursable** if performed after transfer from post-anesthesia recovery to a hospital unit/ICU.

POLICY GUIDELINES

DEFINITIONS

Teaching Physician. A physician (other than another resident) who involves residents in the care of his or her patients.[1]

Medically Directed. When the anesthesiologist is involved in specific aspects of anesthesia services performed by other qualified individuals (e.g., CRNAs, anesthesiologists' assistants, interns, residents, or combinations of these individuals) **and** is *not* performing any other services while directing the concurrent procedures. Documentation in the medical record must support that the physician performed the pre-anesthetic evaluation and examination, as well as indicated post-anesthesia care, was present during some portion of the anesthesia monitoring, and was present during the most demanding procedures in the anesthesia plan (e.g., induction and emergence where indicated).[2]

A physician who is concurrently furnishing services that meet the requirements for payment at the medically directed rate **cannot** ordinarily be involved in furnishing additional services to other patients.

- Addressing an emergency of **short** duration in the **immediate** area, administering an epidural or caudal anesthetic to ease labor pain, periodic (rather than continuous) monitoring of an obstetrical patient, receiving patients entering the operating suite for the next surgery, checking or discharging patients in the recovery room, or handling scheduling matters, do not substantially diminish the scope of control exercised by the physician and do not constitute a

separate service for the purpose of determining whether the requirements for payment at the medically directed rate are met.[2]

- ❖ 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 would **not** meet the requirements for payment at the medically directed rate.[2]

Medically Supervised. Furnishing more than four procedures concurrently **or** performing other services while directing the concurrent procedures.[2]

Physically Present. The teaching physician is located in the same room (or partitioned or curtained area, if the room is subdivided to accommodate multiple patients) as the patient and/or performs a face-to-face service.[1]

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

GENERAL

CMS References

The above criteria and reimbursement methodologies are consistent with the CMS guidance regarding anesthesia reimbursement. As of 6/24/2025, the following Centers for Medicare & Medicaid (CMS) guidance was identified which addresses anesthesia reimbursement:

- Noridian J-F web page for Modifiers.
- Noridian J-F web page for Anesthesia and Pain Management.
- Centers for Medicare & Medicaid Services (CMS). Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners. *(Multiple subsections in this reference provide relevant information).*

Both of the above Noridian web pages state:

> *"Physician status (P1-P6) - not recognized by Medicare."*

Oregon Health Plan (OHP)

The OHP Oregon Administrative Rule (OAR) 410-130-0368 for Anesthesia Services states as follows:

> *"Reimbursement for qualifying circumstances codes 99100-99140 and modifiers P1-P6 is bundled in the payment for codes 00100-01999. Do not add charges for 99100-99140 and modifiers P1-P6 in charges for 00100-01999."*

Additional References

Additional references include CPT Manual and guidelines published by the American Society of Anesthesiologists (ASA).

BILLING AND CODING GUIDELINES

GENERAL

Anesthesia may be performed by a single individual, who oversees the entire anesthesia service, or by multiple anesthesia providers, overseen by a physician (anesthesiologist). How the anesthesia service is performed determines how the service is coded, and subsequently, how it is reimbursed.

Anesthesia Payment Modifiers

Table 1 below is a list of payment modifiers for anesthesia codes.

Table 1: Anesthesia Payment Modifiers

Payment Modifiers	
Modifier	**Description**
AA	Anesthesia services performed personally by anesthesiologist
AD	Medical supervision by a physician: more than 4 concurrent anesthesia procedures
GC	This service has been performed in part by a resident under the direction of a teaching physician
QK	Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals
QX	Qualified nonphysician anesthetist with medical direction by a physician
QY	Medical direction of one qualified nonphysician anesthetist by an anesthesiologist
QZ	CRNA service: without medical direction by a physician

Personally Performed Anesthesia Services

When the physician or anesthesiologist performs all anesthesia services personally, the services are reported using modifier AA.

Medically Directed Anesthesia Services

When the physician is continuously involved in **one** anesthesia case involving a Certified Registered Nurse Anesthetist (CRNA) or Anesthesiology Assistant (AA), and the physician is performing medical direction:

- The physician will use the modifier “QY,” and
- the CRNA or AA will use the modifier “QX.”

When the physician is involved in the medical direction of **2,3 or 4 concurrent** anesthesia procedures involving CRNA’s:

- The physician will use the modifier “QK,” and
- the CRNA will use the modifier “QX.”

Non-Medically Directed CRNA Anesthesia Services

When the CRNA provides anesthesia services without medical direction by a physician, the CRNA will use the modifier “QZ.”

Medically Supervised Anesthesia Services

When the physician is involved in **more than four** concurrent anesthesia procedures.

- The physician reports using "AD" modifier, and
- the CRNA reports using the "QX."

Services Integral to Anesthesia Procedures

Anesthesia HCPCS/CPT codes include all services integral to the anesthesia procedure, such as preparation, monitoring, intra-operative care, and post-operative care until the patient is released by the anesthesia practitioner to the care of another physician.[3,4] Examples of integral services considered part of the base value include, but are not limited to, the following:

- Usual preoperative and postoperative visits.
- Anesthesia care during the procedure.
- Administration of blood and other fluids.
- Usual monitoring services (e.g., ECG, temperature, blood pressure, oximetry, capnography, mass spectrometry.
- Transporting, positioning, prepping, draping of the patient for satisfactory anesthesia induction/surgical procedures.
- Placement of peripheral intravenous lines for fluid and medication administration.
- Placement of airway (e.g., endotracheal, orotracheal) tubes or nasogastric or orogastric tubes.
- Laryngoscopy (direct or endoscopic) for placement of airway (e.g., endotracheal tube).
- Intra-operative interpretation of monitored functions (e.g., blood pressure, heart rate, respirations, oximetry, capnography, temperature, EEG, brainstem-evoked response [BSER], Doppler flow, central nervous system [CNS] evoked responses and pressure, etc.), including the placement of such monitoring devices.
- Interpretation of laboratory determinations (e.g., arterial blood gases such as pH, pO2, pCO2, bicarbonate, CBC, blood chemistries, lactate) by the anesthesiologist/CRNA.
- Nerve stimulation for determination of level of paralysis or localization of nerve(s). (Codes for Electromyography (EMG) services are for diagnostic purposes for nerve dysfunction. To report these codes a complete diagnostic report must be present in the medical record.)
- Insertion of urinary bladder catheter.
- Blood sample procurement through existing lines or requiring venipuncture or arterial puncture.

Although some of these services may never be reported on the same date of service as an anesthesia service, many of these services could be provided at a separate patient encounter unrelated to the anesthesia service on the same date of service. In these situations, providers may use modifier 59 or XE, when appropriate.

Anesthesia Services Not Included in the Base Value

The following services are not included in the base value for the anesthesia service, and therefore, may be billed separately when supported by documentation:[3]

- Placement of arterial, central venous, and pulmonary artery catheters.
- Injections for postoperative pain control billed by anesthesiologist:

- An epidural injection (CPT codes 623XX) for postoperative pain management requested by the surgeon may be reported separately with an anesthesia (0XXXX) code only if the mode of intraoperative anesthesia is general anesthesia and the adequacy of the intraoperative anesthesia is not dependent on the epidural or peripheral block injection.
- A peripheral nerve block injection (CPT codes 64XXX) for postoperative pain management requested by the surgeon may be reported separately with an anesthesia (0XXXX) code only if the mode of intraoperative anesthesia is general anesthesia, subarachnoid injection, or epidural injection, and the adequacy of the intraoperative anesthesia is not dependent on the peripheral nerve block injection.
- An epidural or peripheral nerve block injection administered preoperatively or intraoperatively is not separately reportable for postoperative pain management if the mode of anesthesia for the procedure is MAC, moderate conscious sedation, regional anesthesia by peripheral nerve block, or other type of anesthesia not identified above.

Postoperative Pain Control Billed by Facilities

Reimbursement to facilities for the control or management of pain in the immediate postoperative period is packaged into payment for the surgical or anesthetic procedure, regardless of the method by which the care provider, including the anesthesiologist, decides to manage pain. Following discharge from the post-anesthesia care unit (PACU), medically necessary and reasonable placement of regional or peripheral pain blocks or initiation of other new pain interventions or "top-up" dosing may be separately reimbursable in the outpatient setting. Facilities should not expect separate payment for the establishment of epidural or other pain blocks unless the block is placed following discharge from PACU when documentation supports the intervention.

PHYSICAL STATUS MODIFIERS

The American Society of Anesthesiologists (ASA) Physical Status Classification System has been in use for several decades and is used to "assess and communicate a patient's pre-anesthesia medical co-morbidities."[5] Table 1 below includes definitions and examples, but this is not an all-inclusive list. Additional examples may be available on the ASA website, including examples specific to pediatrics and obstetrics.[5]

Physical status modifiers are **not** recognized for Medicare[6,7] or OHP/Medicaid[8] members, and thus, no additional reimbursement is allowed for any of these Plan members. However, physical status modifiers may be allowed for lines of business ***other than*** Medicare and OHP/Medicaid, and are subject to ASA Guidelines. As with all services, documentation to support the charge must be included in the medical record.

Table 2: Physical Status Modifiers and American Society of Anesthesiologists (ASA) PS Classifications

Physical Status Modifiers		
ASA Status / Modifier	**Pre-Operative Health Status**	**Comments/Examples**
ASA I / P1	A normal healthy patient.	No organic, physiologic, or psychiatric disturbance; excludes the very young and very old; healthy with good exercise tolerance
ASA II / P2	A patient with mild systemic disease.	No functional limitations; has a well-controlled disease of one body system; controlled hypertension or diabetes without systemic effects, cigarette smoking without chronic

		obstructive pulmonary disease (COPD); mild obesity, pregnancy
ASA III / P3*	A patient with severe systemic disease.	Some functional limitation; has a controlled disease of more than one body system or one major system; no immediate danger of death; controlled congestive heart failure (CHF), stable angina, old heart attack, poorly controlled hypertension, morbid obesity, chronic renal failure; bronchospastic disease with intermittent symptoms
ASA IV / P4	A patient with severe systemic disease that is a constant threat to life.	Has at least one severe disease that is poorly controlled or at end stage; possible risk of death from anesthesia; unstable angina, symptomatic COPD, symptomatic CHF, hepatorenal failure
ASA V / P5**	A moribund patient who is not expected to survive without the operation.	Not expected to survive > 24 hours without surgery; imminent risk of death; multiorgan failure, sepsis syndrome with hemodynamic instability, hypothermia, poorly controlled coagulopathy
ASA VI / P6	A declared brain-dead patient whose organs are being removed for donor purposes.	

*Patients with multiple PS 3 conditions may qualify as PS 4.
**PS modifier 5 may be subject to medical review.

OBSTETRIC ANESTHESIA CODES

Obstetric anesthesia is unique in that often involves extensive hours, which may result in the transfer of anesthesia to a second physician.

- 01960: Anesthesia for vaginal delivery only
- 01961: Anesthesia for cesarean delivery only
- 01967: Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor).

Use CPT® procedure code 01967 for labor and vaginal delivery.

Codes 01968 and 01969 are add-on codes, meaning they're used in conjunction with a primary code, which in this case, is 01967.

- 01968: Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed)
- 01969: Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed)

Use add-on code 01968 for a cesarean **delivery**, and add-on code 01969 for a cesarean **hysterectomy**, in addition to 01967. Normally, add-on codes are required to be reported the same claim, for the same date of service, and by the same provider as the base or primary procedure code. However, because the

neuraxial labor anesthesia service may begin ***prior*** to midnight, while the cesarean or hysterectomy occurs ***after*** midnight, and/or because anesthesia care may be transferred from one provider to another during the course of the entire obstetric encounter, the Plan will allow add-on CPT codes 01968 and 01969 when billed with the primary anesthesia code 01967, regardless of whether by the same or different individual physician or other qualified healthcare professional.

As with all services, obstetric anesthesia services must be billed coded and reported in a manner that appropriately reflects anesthesia services rendered, and reasonably reflects the costs of providing labor analgesia, as well as including the intensity and time involved in performing and monitoring any neuraxial labor analgesic. Labor and delivery anesthesia is different from other surgical anesthesia in that personal attendance by the anesthesiologist or CRNA is not required throughout the neuraxial labor anesthesia (01967).

The American Society of Anesthesiologists (ASA) provides a "Relative Value Guide®" or RVG™. This reference includes a special section on obstetric anesthesia within the Anesthesia Guidelines, and states the following:

> *"Unlike operative anesthesia services, there is no single, widely accepted method of accounting for time for neuraxial labor anesthesia services.*
>
> *Professional charges and payment policies* ***should reasonably reflect the costs of providing labor anesthesia services as well as the intensity and time involved in performing and monitoring any neuraxial labor anesthesia service.****"*

This reference also provides four (4) methods for billing for this anesthesia service. Consistent with one of these reimbursement methodologies described in the ASA RVG, the Plan will reimburse neuraxial labor analgesia (CPT code 01967) based on Base Unit Value plus Time Units subject to a cap.[9]

Reporting for the full duration a patient has an epidural is not correct, as these are not billed as one single, continuous or uninterrupted charge. For example, if an epidural starts on day one, and ends on day three (72 hours later), reporting for the full 72 hours would be incorrect.

Rather, time for this service is reported based on the time spent for distinct activities, such as insertion, management of adverse events, delivery, and removal. The reported time in minutes means the time during which the anesthesia provider is both furnishing continuous anesthesia care to a patient **and** is physically present with the patient.

CROSS REFERENCES

Coding Policies

- Bundled Services, CP13
- Global Surgical Package, CP12

Reimbursement Policies

- Associated Services and Related Claims, RP9
- Reasonable Billing Practices, RP14

The full Company portfolio of current Reimbursement Policies is available online and can be accessed here.

REFERENCES

1. Centers for Medicare and Medicaid Services (CMS). Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners, § 100 - Teaching Physician Services. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c12.pdf. Accessed 8/6/2025
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3. CMS. National Correct Coding Initiative (NCCI). Ch. 2, Anesthesia Services.
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9. American Society of Anesthesiologists (ASA). https://www.asahq.org/quality-and-practice-management/managing-your-practice/timely-topics-in-payment-and-practice-management/coding-and-billing-for-labor-epidurals. Accessed 8/20/2025.
10. CMS. Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners, § 140 - Qualified Nonphysician Anesthetist Services. Updated 2024. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf. Accessed 6/25/2025.

POLICY REVISION HISTORY

Date	Revision Summary
12/2025	New reimbursement policy (previously Coding Policy 9.0, *Anesthesia*)