AmeriHealth Caritas Ohio

Anesthesia

Reimbursement Policy ID: RPC.0028.7700

Recent review date: 01/2025

Next review date: 12/2025

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

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

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

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

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

Exceptions

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

Reimbursement Guidelines

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

Required Anesthesia Modifiers

All anesthesia services, including monitored anesthesia care, must be submitted with a required anesthesia modifier in the first modifier position. These modifiers identify whether a procedure was personally performed, medically directed, or medically supervised.

Required Anesthesia Modifier	Provider Type
AA	Anesthesiologist physician, personally performed
AD	Anesthesiologist physician, supervising over 4 concurrent anesthesia procedures
QK	Anesthesiologist physician, Supervising 2-4 concurrent anesthesia procedures
QX	CRNA* or AA* directed by anesthesiologist physician
QY	Anesthesiologist physician, supervising 1 anesthesia procedure
QZ	CRNA, personally performed

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

Physical Status Modifiers

CPT and American Society of Anesthesiologists guidelines identify six levels of ranking for patient physical status. Appending a physical status modifier to a time-based anesthesia code identifies the level of complexity. Modifying unit(s) are added to the base unit value for the most complex situations. If more than one physical status modifier (P3, P4, or P5) is submitted, the modifier with the highest number of units is the reimbursable service.

Physical Status Modifier and Description	Modifying Units added to the base unit value
P1 — a normal healthy patient	0 units
P2 — a patient with mild systemic disease	0 units
P3 — a patient with moderate systemic disease	1 unit
P4 — a patient with severe systemic disease that is a constant threat to life	2 units
P5 — a moribund patient who is not expected to survive without the operation	3 units
P6 — a declared brain-dead patient whose organs are being removed for donor purposes	0 units

Informational Modifiers

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

CPT Modifier	CPT Modifier description	HCPCS Modifier	HCPCS Modifier description
23	Provider administered general anesthesia for a procedure that does not normally require it.	GC	Added to a CPT code for service(s) performed in part by a resident under the direction of a teaching physician
47	Anesthesia administered by the surgeon	G8	Monitored anesthesia care (MAC) for a deeply complex, complicated, or markedly invasive surgical procedure
		G9	Monitored anesthesia care (MAC) for a patient who has history of severe cardiopulmonary condition
		QS	Monitored anesthesia care (MAC) services

Base Values

Each CPT anesthesia code (00100-01999) is assigned a base value by the American Society of Anesthesiologists, and AmeriHealth Caritas Ohio uses these values for determining reimbursement. The base value for each code is comprised of units referred to as the base unit value.

Time Reporting
Consistent with CMS guidelines, AmeriHealth Caritas Ohio requires time-based anesthesia services be reported with actual anesthesia time in one-minute increments. For example, if the anesthesia time is one hour, then 60 minutes should be submitted.

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

For neuraxial labor analgesia, the time unit begins when the analgesic is inserted and ends at delivery. Total duration is limited to two hundred forty minutes (four hours).

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

Definitions

N/A

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. Healthcare Common Procedure Coding System (HCPCS).
III. American Society of Anesthesiologists Relative Value Guide (ASA-RVG).
IV. Centers for Medicare and Medicaid Services (CMS), Chapter 2, CPT Codes 00000-01999.
V. Ohio Administrative Code 5160-4-21.

Attachments

N/A

Associated Policies

N/A

Policy History

06/2025	Minor updates to formatting and syntax
04/2025	Revised preamble
01/2025	Reimbursement Policy Committee Approval
11/2024	Annual Review • Addition of maternity anesthesia
04/2024	Revised preamble
02/2024	Reimbursement Policy Committee Approval
08/2023	Removal of policy implemented by AmeriHealth Caritas Ohio from Policy History section
01/2023	Template revised • Revised preamble • Removal of Applicable Claim Types table • Coding section renamed to Reimbursement Guidelines Added Associated Policies section