

# Anesthesia

## Policy

Harvard Pilgrim reimburses anesthesia services to contracted anesthesia providers for the induction of general or regional anesthesia and supportive services associated with the provision of optimal anesthesia care for medical or surgical procedures.

## Policy Definition

*Anesthesia* is the loss of feeling or sensation as a result of medications or gases. General anesthesia causes loss of consciousness. Local or regional anesthesia numbs only a certain area.

## Prerequisite(s)

Applicable Harvard Pilgrim referral, notification and authorization policies and procedures apply. Refer to [\*Referral, Notification and Authorization\*](#) for more information.

## HMO/POS/PPO

A referral is required for outpatient specialist services for HMO and in-network POS members.

### Open Access HMO and POS

For [\*Open Access HMO and Open Access POS\*](#) products, no referral is required to see a contracted specialist.

## Harvard Pilgrim Reimburses<sup>1</sup>

### HMO/POS/PPO

- Anesthesia services to contracted anesthesia providers using the American Society of Anesthesiologists (ASA) codes and the Anesthesia Unit System
- The procedure with the highest unit value only, when multiple surgical procedures are billed during a single anesthetic administration
- Based on the sum of the allowable base and time units
  - Anesthesia units include:
    - Basic values as defined by the ASA (Harvard Pilgrim automatically assigns base values) and
    - A time unit of 15 minutes or a pro-rated portion thereof based on the actual minutes submitted.
  - Anesthesia time starts when the anesthesiologist begins to prepare the patient for induction and ends when the patient can safely be placed under post-operative supervision.
- Insertion of an inter-arterial monitoring line during surgery
- Insertion of a central venous pressure monitoring line during surgery
- Transesophageal echocardiography when performed with general anesthesia for monitoring and diagnostic services
- Placement of Swan Ganz catheter
- General anesthesia for procedures other than surgical (diagnostic tests, exams, etc.) using base plus time methodology
- Monitored anesthesia care
- Radiological services requiring general/regional anesthesia/deep sedation using base plus time methodology
- Radiation oncology services using base plus time methodology
- Discontinuous anesthesia time as long as there is continuous monitoring of the patient within the discontinuous blocks of time
- Medically directed services
  - Harvard Pilgrim recognizes CMS's definition of medical direction and supervision. Only an anesthesiologist will be reimbursed for medical direction services.
  - Harvard Pilgrim reimburses medical direction by an anesthesiologist of procedures performed by a certified nurse anesthetist (CRNA) or qualified individual as follows:

- 50% of the allowable amount recognized for the service to the anesthesiologist and 50% to the CRNA or other qualified individual
- Supervision of more than four concurrent procedures is based on three base units unless documentation of the anesthesiologist is present for intubation; if so, reimbursement is based on four base units
- Teaching anesthesiologists for procedures performed by residents.
  - Payment may be made if the teaching anesthesiologist is involved in the training of a resident in a single anesthesia case, two concurrent anesthesia cases involving residents, or a single anesthesia case involving a resident that is concurrent to another case paid under the medical direction rules.
  - To qualify for payment, the teaching anesthesiologist must be present during all critical or key portions of the anesthesia service or procedure involved. The teaching anesthesiologist must be immediately available to furnish anesthesia services during the entire procedure. The documentation in the patient's medical records must indicate the teaching physician's presence during all critical or key portions of the anesthesia procedure and immediate availability.
- Obstetrical anesthesia
- Reimbursement for neuraxial/epidural labor is based on the actual time unit capped at the following minutes:
  - Vaginal delivery codes are capped at a total of 225 minutes/15-*time* units
  - Cesarean section delivery codes are capped at a total of 270 minutes/18-*time* units
- Reimbursement includes repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor
- Post-operative or medical pain management services reimbursed when:
  - Requested in writing by a Harvard Pilgrim ordering physician
  - Epidural or spinal analgesia is used to manage post-operative pain or a medical diagnosis (e.g., oncology), including
    - Administration of epidural/spinal analgesia by a single narcotic injection
    - Insertion of an epidural or spinal catheter for continuous post-operative pain management (Fee includes the catheter insertion and all narcotic administration on that date)
    - An epidural or spinal catheter is placed primarily for post-operative pain control on the day of surgery
  - Harvard Pilgrim follows CPT reporting directions for subsequent daily pain management services
  - Patient-controlled analgesia is performed subsequent to the day of surgery

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### Outpatient Pain Management

Outpatient pain management reimbursed as follows:

- Regional blocks or therapeutic injections, when performed by the anesthesiologist at a standard surgical rate methodology, not base plus time
- Trigger point injections
- Fluoroscopic guidance and localization when appropriate
- Outpatient evaluation and management codes

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### Multiple Procedures

- When anesthesiologists perform multiple pain management or surgical CPT procedures at the same session, the primary procedure is reimbursed at 100% of the allowable rate and all subsequent reimbursable procedures are paid at 50% of the allowable rate.
- Harvard Pilgrim determines the primary procedure based on the highest allowable rate, not the charge.

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### Harvard Pilgrim Does **Not** Reimburse

#### HMO/POS/PPO

- CPT surgical codes used to report the primary general anesthesia service
- Activities considered part of anesthesia services:
  - All usual pre- and post-operative services
  - Induction of anesthesia during the procedure
  - Incidental administration of parental fluids and/or blood products
  - Usual monitoring procedures associated with the complexity of the service

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- CPT codes designated by the ASA as not normally requiring anesthesia
- Qualifying circumstances for anesthesia
- Evaluation and management services if part of the routine pre- and post-anesthetic service
- Ventilation management related to the surgery anesthesia
- Therapeutic services such as pulmonary function testing related to the general anesthesia service
- Evaluation and management services for post-operative pain control on the day of surgery
- The insertion of a catheter on the same day that epidural anesthesia was delivered during surgery (It is included in the base value of the anesthesia care.)
- Inpatient pain management services on the same day of service as the insertion of an epidural catheter or single epidural injection

Please refer to the coding grid for information on the following:

- Services requested after hours
- Services provided in the office during regularly scheduled evening, weekend or holiday hours
- Services provided between 10 p.m. and 8 a.m. at a 24-hour facility
- Services provided on an emergency basis
- Services requested on Sundays and holidays
- Anesthesia and moderate sedation services (00300, 00400, 00600, 01937-01942, 01991-01992, 99152-99153, 99156-99157) will not be reimbursed when billed with pain management services and billed without a surgical code (10021-69990) by any provider for a member age 18 or older.

### Outpatient Pain Management Services

- Comprehensive pain clinics. (Components of the program that would be covered on an individual basis under Harvard Pilgrim policies may be reimbursed.)
- Pulsed radiofrequency of a nerve
- Pudendal nerve decompression
- Occipital nerve stimulation for intractable headaches

### Member Cost-Sharing

Services subject to applicable member out-of-pocket cost (e.g., copayment, coinsurance, deductible).

### Provider Billing Guidelines and Documentation

#### Coding<sup>2</sup>

#### General

Code	Description	Comments
0963	Professional Anesthesia MD	Bill with CPT/ASA code
0964	Professional Anesthesia RN	
00100–01999	ASA anesthesia codes	Used to report primary general anesthesia service
01953	Anesthesia for second and third degree burn excision; each additional 9%	Do not report with time units
36620	Arterial catheterization or cannulation for sampling, monitoring or transfusion, percutaneous	Reimbursed with general anesthesia service; 36555-6 is reimbursed with CPT 93503 if service is separate and distinct and reported with the appropriate modifier
62320-62323	Injection of a diagnostic/therapeutic substance not via an indwelling catheter	

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Code	Description	Comments
64413, 64415, 64416-64425, 64445-64451, 64454-64455	Injection(s) of anesthetic agent(s)	Reimbursed with ASA codes when procedure is separate and distinct and reported with the appropriate modifier
93503	Insertion and placement of flow directed catheter (e.g., Swan-Ganz) for monitoring	Reimbursed with general anesthesia service
99051	Services provided in the office during regularly scheduled evening, weekend or holiday hours in addition to the basic service	Not reimbursed
99053	Services provided between 10:00 p.m.–8:00 a.m. at a 24-hour facility in addition to the basic service	Not reimbursed
99060	Services(s) provided on an emergency basis, out of the office, which disrupts other scheduled office visits in addition to the basic service	Not reimbursed
99100, 99116, 99135, 99140	Qualifying circumstances for anesthesia	Not reimbursed

When multiple surgical procedures are performed during a single anesthetic session, only the anesthesia code with the highest base value is reported:

- Harvard Pilgrim will automatically assign base units.
- Enter the supervising or directing physician's name in block 31 of the CMS-1500 form or loop 2310D, NM1 segment with the DQ qualifier of the electronic 837 claim.
- When a physician group employs CRNAs, bill CRNA services using the group name and ID in block 33, 33b and 33a of the CMS-1500 form or loop 2010AA, NM1 segment with the 85 qualifier of the electronic 837 claim, if available.
- Report discontinuous anesthesia time as the sum of the continuous anesthesia block times.

## Moderate (Conscious) Sedation

Code	Description	Comments
G0500	Moderate sedation services provided by the same physician or other qualified health care professional performing a gastrointestinal endoscopic service (excluding biliary procedures) that the sedation supports (additional time may be reported with 99153, as appropriate)	Bill with CPT 43200-45398, HCPCS G0105 AND G0121
99151-99152	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status	CPT 99152 not reimbursed when billed with CPT 43200-45398, HCPCS G0105 AND G0121. (See G0500)
99153	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or	Use in addition to G0500 or 99151, 99152

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	therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; each additional 15 minutes intraservice time (List separately in addition to code for primary service)	
99157	Moderate sedation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intraservice time (List separately in addition to code for primary service)	Use in addition to 99155-99156

### Obstetrical

Code	Description	Comments
01960	Anesthesia for vaginal delivery only	Bill when no neuraxial/anesthesia is involved with vaginal delivery; not reimbursed with 01967
01961	Anesthesia for Cesarean delivery only	Use to report anesthesia services for a planned cesarean section; not reimbursed with 01968
01967	Neuraxial labor analgesia/anesthesia for planned vaginal delivery	Time unit cap limits apply; use to report epidural labor and vaginal delivery
01968	Anesthesia for cesarean delivery following neuraxial labor/anesthesia	Must be reported in addition to 01967; use to report when a planned vaginal delivery turns into a cesarean section; not reimbursed when billed alone; this code in combination with 01967, is subject to the cap limits for C-sections (e.g., 01967 billed with 01968 is subject to a combined cap limit of 270 minutes)
01969	Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia	Must be reported in addition to 01967; not reimbursed when billed alone

### Pain Management

- Bill for pre-anesthesia services when surgery is cancelled after pre-operative anesthesia work-up with inpatient consultation codes.
- Do not report pain management services with time/minutes.

Code	Description	Description Comments
01996	Daily hospital management of epidural or subarachnoid continuous drug administration	Bill for subsequent daily pain management services; use of 01996 on the same day when catheter was used to deliver anesthesia is inappropriate
62324-62327	Injection, including catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (e.g., anesthetic, antispasmodic, opioid, steroid, other solution) not including neurolytic substances, interlaminar epidural or subarachnoid; cervical	Bill for catheter insertion for pain management when not used as the anesthetic; when catheter is placed as mode of anesthesia and retained for post-operative pain management use, this code is not reported; bill with anesthesia code procedure only;

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Code	Description	Description Comments
	or thoracic, lumbar, sacral (caudal) with or without imaging guidance	Reimbursed with ASA codes when procedure is separate and distinct and reported with the appropriate modifier
99211-99215	Outpatient evaluation and management codes	Bill for outpatient pain management services

### Modifiers

Harvard Pilgrim requires the use of the following modifiers as appropriate for claims submitted by anesthesiologists when reporting anesthesia services.

Code	Description	Comments
AA	Anesthesia services performed personally by anesthesiologist	Allows 100% of fee schedule/allowable rate Payment based on the appropriate unit rate
AD	Medical supervision for more than four concurrent anesthesia procedures is provided (documentation required)	Reimbursed at a rate equal to three base units plus one additional unit if the physician was present for intubation
G8	Monitored anesthesia care (MAC) for deep, complex, complicated or markedly invasive surgical procedures	
G9	Monitored anesthesia care for a patient who has a history of severe cardiopulmonary condition	
GC	Services performed in part by a resident under the direction of a teaching physician	Services are reimbursable at 100% of the allowable when billed by the teaching anesthesiologist. (Note: the teaching anesthesiologist must bill with the "AA" modifier in the first field and the "GC" certification modifier in the second field.)
P1-P6	Physical status modifiers	Modifiers are required and should be reported in the secondary modifier position. These modifiers will not impact reimbursement.
QS	Monitored anesthesia care (MAC) provided by an anesthesiologist	
QZ	CRNA performed services without medical direction	
QY	Anesthesiologist medically directed one CRNA	Allows 50% of fee schedule/allowable rate Payment based on the appropriate unit rate
QK	Medical direction of two, three or four concurrent anesthetic procedures involving qualified individuals (e.g., CRNAs or residents)	
QX	CRNA performed services under the medical direction of an anesthesiologist	

### Other Information

Must bill total time in minutes in block 24G; do not use time units; reporting units may result in an incorrect payment.

- Submit paper claims with the elapsed time in minutes clearly shown in the narrative.
- Submit electronic claims using the designated minute field, loop 2400, segment SV1, data element SV103 with the MJ qualifier. (Use three digits to record minutes, e.g., 33 minutes = 033.)

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- Physical status modifiers for anesthesia are required.

### Related Policies

#### Payment Policies

- Evaluation and Management
- Non-Covered Services
- Surgery

#### Clinical Policies

- Monitored Anesthesia Care for Gastrointestinal Endoscopic Procedures
- Implantable Neurostimulators
- New Technology Assessment and Non-Covered Services

### PUBLICATION HISTORY

01/01/01	original documentation
07/15/01	reimbursement changes for insertion of intra-arterial, central venous pressure, and transesophageal monitoring
01/01/03	annual review; clarified pain management and billing
04/01/01	further clarification of pain management and reimbursement billing
04/03/04	after-hours service information added; analgesia info added for post-operative or medical pain management; patient controlled analgesia removed; AA modifier clarified
04/01/05	annual review
10/31/05	ASA coding change and billing rules
01/31/06	2006 annual coding update
04/01/06	annual review; added after hours codes and chemodenervation other eccrine glands to non-reimbursed services
01/31/07	2007 annual coding update; revised minute calculation
04/30/07	added reimbursement for transesophageal echocardiography; added no reimbursement for pulsed radiofrequency of nerves
04/30/08	annual review; clarified GC modifier; removed no reimbursement for chemodenervation of eccrine glands
01/01/09	revised billing guidelines to no longer require anesthesia modifiers for non-ASA codes; added reporting requirements for billing 36555-56 with 93503 and for pain injection codes with ASA codes; removed nonpayment for subsequent inpatient visit codes
01/15/10	annual review; updated policy for non reimbursement for pudendal nerve decompression and occipital nerve stimulation for intractable headaches
01/15/11	annual review; added new codes to occipital nerve stimulation and pudendal nerve decompression that are not reimbursed
12/15/11	annual review; minor edits for clarity
01/01/12	removed First Seniority Freedom information from header
12/15/12	annual review; no changes
01/15/13	annual review; added multiple procedure reduction language effective 04/01/13
12/15/13	annual review; no changes
06/15/14	added <i>Connecticut Open Access HMO</i> referral information to prerequisites
12/15/14	annual review; added info about residents and electronic billing guidelines
12/15/15	annual review; updated non-covered code range for moderate sedation; updated electronic billing guidelines for pain management
01/15/16	annual coding update
09/15/16	updated physical status modifiers and added related medical policy
12/15/16	annual review; administrative edits
01/15/17	annual coding update
02/15/17	added moderate (conscious) sedation
12/15/17	annual review; no changes
01/01/18	updated Open Access Product referral information under Prerequisites
12/03/18	annual review; updated Related Policies; administrative edits
05/01/19	updated anesthesia and moderate sedation will no longer be reimbursed when billed with pain management services as of 07/01/19 for members age 18 or older
01/02/20	annual review; clarified reimbursement to contracted anesthesia providers
02/03/20	annual coding update
01/04/21	annual review; updated Provider Billing Guidelines and Documentation
03/01/21	added "allowable rate" to AA,QY,QK and QX modifiers
12/01/21	annual review; administrative edits, removed consultation codes, added related policies
02/01/22	annual coding update

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01/02/24	annual review; updated Related Policies
12/31/24	annual review; administrative edit

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<sup>1</sup>This policy applies to the products of Harvard Pilgrim Health Care and its affiliates, Harvard Pilgrim Health Care of New England, and HPHC Insurance Company—for services performed by contracted providers. Payment is based on member benefits and eligibility, medical necessity review, where applicable, and provider contractual agreement. Payment for covered services rendered by contracted providers will be reimbursed at the lesser of charges or the contracted rate. (Does not apply to inpatient per diem, DRG, or case rates.) HPHC reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated annually. Always use the most recent CPT and HCPCS coding guidelines.

<sup>2</sup>Tables may not include all provider claim codes related to anesthesia.