PREMERA HMO
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Payment Policy

cmi_051695

Title	**Anesthesia Guidelines**		
Number	**CP.PP.017.v3.7**		
Last Approval Date	03/12/26	**Original Effective Date**	09/01/00
Replaces	N/A		
Cross Reference	• *Medicare Indicator 'Status B and Status T' Services Reimbursement* • *Modifier 22 – Increased Procedural Services*		

Coverage of any service is determined by a member's eligibility, benefit limits for the service or services rendered and the application of the Plan's Medical Policy. Final payment is subject to the application of claims adjudication edits common to the industry and the **Plan's professional or facility services claims coding policies**. Reimbursement is restricted to the provider's scope of practice as well as the fee schedule applicable to that provider.

Purpose	To define how the Plan applies calculated units for anesthesia services and how related anesthesia services are addressed that are submitted on a professional claim.
Scope	Applies to all Premera Blue Cross, Premera Blue Cross Blue Shield of Alaska, LifeWise Health Plan of Washington, LifeWise Assurance Company and Premera Blue Cross HMO lines of business and products.
Policy	**Base and Time Units** The period of time on which anesthesia time units are based **begins** when the anesthesiologist is first in attendance with the patient for the purpose of the induction of anesthesia and **ends** when the patient leaves the operating room or delivery room. Time spent in the recovery room is included in the anesthesia base units and no additional benefits are provided. For a procedure to be considered "anesthesia attendance" and not standby, all of the following must occur: • The service is requested by the attending physician; and • The anesthesiologist documented that he/she was present for the entire procedure and provided all the usual services except actual administration of anesthetic agent and anesthesia attendance must be medically necessary for the patient's surgical procedure and condition. American Society of Anesthesiologists (ASA) codes are utilized to establish base units. For all anesthesia procedure reimbursements based on time, except as noted below, total anesthesia units are calculated based on a four-unit hour. To calculate the number of anesthesia units, the total anesthesia minutes are divided by 15 and rounded to the nearest whole hundredth decimal point using standard rounding methodology: • .5 unit or more is rounded up to the next whole unit. • .4999 units or less is rounded down to the next whole unit. **Obstetrical Anesthesia** Standard base units are allowed for obstetrical delivery epidural anesthesia (code 01967). Labor management will be allowed 3-time units for the **initial hour** of the block and 2-time units for **each additional hour**. To calculate the number of OB anesthesia units, the first 60 anesthesia minutes are divided by 20 and the remaining minutes are divided by 30. The units are then

combined and rounded to the nearest whole hundredth decimal point using standard rounding methodology:

- .5 unit or more is rounded up to the next whole unit.
- .4999 units or less is rounded down to the next whole unit.

Modifiers

An appropriate anesthesia HCPCS modifier is required to be added to each anesthesia service code (codes 00100 – 01992, 01999) submitted in order to identify the level of the provider who rendered the service (e.g., Certified Registered Nurse Anesthetist, resident physician, supervising or directing physician anesthesiologist). Reimbursement of the anesthesia service may be adjusted based on the specific modifier submitted.

Anesthesia services/codes submitted without a modifier will be denied reimbursement.

The Plan recognizes the following modifiers when appended to an anesthesia service, to identify the provider who rendered the anesthesia service(s):

- **23 – Unusual Anesthesia**
  - Appended to an anesthesia procedure that normally does not require anesthesia or local anesthesia and must be performed under **general or monitored anesthesia** a result of unusual circumstances.
  - Added **after** the primary anesthesia modifier which identifies whether the service was personally performed, medically directed, or medically supervised (Modifiers AA, AD, QK, QS, QX, QY or QZ)
  - Not appropriate to be appended to moderate/conscious sedation codes (99151-99153, 99155-99157).

- **AA – Anesthesiology services performed personally by an anesthesiologist**
  - This modifier should not be used by the anesthesiologist when supervision or direction is provided to another anesthesiologist
  - This modifier should be used by any provider who also acts as an anesthesiologist when performing a surgical procedure in the same operative session (e.g., oral surgeons)

- **AD – Medical supervision by a physician: more than four concurrent anesthesia procedures**
  - Used by a physician when supervising four or more concurrent procedures
  - Physician reimbursement will be adjusted to reflect 50% of the provider's applicable Fee Schedule allowed amount

- **QK – Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals**
  - Used when qualified individuals, such as a CRNA, are used to perform anesthesia services
  - Physician supervises two to four of these individuals concurrently
  - Physician reimbursement will be adjusted to reflect 50% of the provider's applicable Fee Schedule allowed amount

- **QX – CRNA service: with medical direction by a physician**

- This modifier is appended to CRNA or Anesthetist Assistant (AA) claims
- Indicates CRNA/AA provided the service but was directed by an anesthesiologist
- CRNA reimbursement will be adjusted to reflect 50% of the provider's applicable Fee Schedule allowed amount

- **QY – Medical direction of one CRNA by an anesthesiologist**
  - This modifier is appended to the anesthesiologist's claim to indicate supervision of one CRNA
  - Physician reimbursement will be adjusted to reflect 50% of the provider's applicable Fee Schedule allowed amount

- **QZ – CRNA service: without medical direction by a physician**
  - The modifier is appended to the CRNA services to indicate no supervision was provided by an anesthesiologist
  - Effective dates of service on and after **March 6, 2026**, reimbursement will change from 100% to 85% of the provider's applicable Fee Schedule allowed amount.

For increased anesthesia service, additional time units should be billed instead of modifier 22 or billed with physical status modifiers to identify that additional work was required to render the anesthesia service.

Physical Status Modifiers

Physical Status Modifiers (P1, P2, P3, P4, P5, and P6) may be added to anesthesia services when warranted. These modifiers distinguish between various levels of complexity of the anesthesia services rendered. Additional unit values may be allowed for some of the physical status modifiers as recommended by the American Society of Anesthesiologists and published in the annual ASA Relative Value Guide.

Qualifying Circumstances Codes

Some anesthesia services may be provided under difficult circumstances, depending on factors such as extraordinary condition of the patient, notable operative condition and/or unusual risk factors. Qualifying circumstances codes (99100-99140) may be applied when indicated and documented. These codes are identified as Medicare Status B codes and are not eligible for reimbursement.

Moderate/Conscious Sedation

For moderate sedation provided by a physician or other qualified healthcare professional **who also performed** the diagnostic or therapeutic service that the sedation supports, the codes 99151, 99152 or add-on code 99153 should be used based on time increments of 15 minutes and the age of the patient.

For moderate sedation provided by a physician or other qualified healthcare professional **other than** the provider performing the diagnostic or therapeutic service that the sedation supports, the codes 99155, 99156 or add-on code 99157 should be used based on time increments of 15 minutes and the age of the patient.

	Similar to other timed codes, these codes require that more than half of the time noted, 8 minutes, be provided and documented in order to report these moderate sedation services. To assist in determining how to use the above noted codes based on time, refer to the Table included in the Medicine section of the CPT Codebook under the section "Moderate (Conscious) Sedation." **Related Care** Evaluation and management (E&M) services submitted one day preoperatively, on the same date of service or one day postoperatively will be included with any anesthesia procedure assigned a global day period of "XXX" as identified in the Centers for Medicare and Medicaid Services (CMS) National Physician Fee Schedule. These E&M services are considered part of the global anesthesia service. A pre-anesthesia evaluation by the anesthesiologist **when the procedure is delayed** is not considered a separate procedure. It is considered an integral part of the subsequent anesthesia services. A pre-anesthesia evaluation by the anesthesiologist **when surgery is canceled** may be covered at the level of care rendered as a hospital or office visit. Local anesthesia is considered to be an **integral part of the surgical procedure,** and no additional benefits are provided. Anesthesia time is not required for nerve blocks which are reimbursed based on relative value units only.

This policy was published on March 18, 2026

Codes/Coding Guidelines	The codes listed below pertain to this policy: **Obstetrical Anesthesia:** **01967** – Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor) **Anesthesia Modifiers:** • **23** – Unusual Anesthesia • **AA** – Anesthesiology services performed personally by anesthesiologist • **AD** – Medical supervision by a physician: more than four concurrent anesthesia procedures • **QK** – Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals • **QX** – CRNA service: with medical direction by a physician • **QY** – Medical direction of one CRNA by an anesthesiologist • **QZ** – CRNA service: without medical direction by a physician **Physical Status Modifiers:** • **P1** – A normal healthy person • **P2** – A patient with mild systemic disease • **P3** – A patient with severe systemic disease • **P4** – A patient with severe systemic disease that is a constant threat to life • **P5** – A moribund patient who is not expected to survive without the operation • **P6** – A declared brain-dead patient whose organs are being removed for donor purposes **Qualifying Circumstances Codes:** • **+99100** – Anesthesia for patient of extreme age, younger than 1 year and older than 70 (list separately in addition to code for primary anesthesia procedure) • **+99116** – Anesthesia complicated by utilization of total body hypothermia (list separately in addition to code for primary anesthesia procedure) • **+99135** – Anesthesia complicated by utilization of controlled hypotension (list separately in addition to code for primary anesthesia procedure) • **+99140** – Anesthesia complicated by emergency conditions (specify) (list separately in addition to code for primary anesthesia procedure) (+ = Add-on code; use with appropriate primary anesthesia procedure) **Moderate/Conscious Sedation:** • **99151** – Moderate sedation services provided by the same physician or other qualified healthcare 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; initial 15 minutes of intraservice time, patient younger than 5 years of age • **99152** – Moderate sedation services provided by the same physician or other qualified healthcare 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; initial 15 minutes of intraservice time, patient age 5 years or older

	• **+99153 –** Moderate sedation services provided by the same physician or other qualified healthcare 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; each additional 15 minutes intraservice time (list separately in addition to code for primary service) • **99155 –** Moderate sedation services provided by a physician or other qualified healthcare professional other than the physician or other qualified healthcare professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient younger than 5 years of age • **99156** – Moderate sedation services provided by a physician or other qualified healthcare professional other than the physician or other qualified healthcare professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient age 5 years or older • **+99157** - Moderate sedation services provided by a physician or other qualified healthcare professional other than the physician or other qualified healthcare 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) (+ = Add-on code; use with appropriate primary anesthesia procedure) Per the American Society of Anesthesiologists billing criteria, when multiple surgical procedures are performed during a single anesthetic administration, only the anesthesia code with the highest base value is reported. Combine the total time for all anesthesia procedures on the code with the highest base value.
Violations of Policy	Violations of this policy by any party that enters into a written arrangement with the Plan may result in increased auditing and monitoring, performance guarantee contractual penalties, and/or termination of the contract. Disciplinary actions will be determined by the Plan.
Exceptions	Exceptions to the policy may also be made where a provider contract dictates otherwise. Effective November 24, 2024, the following procedure code does not require an anesthesia modifier: • 01996 - Daily hospital management of epidural or subarachnoid continuous drug administration
Laws, Regulations & Standards	N/A
References	• American Society of Anesthesiologists Relative Value Guide (ASA/RVG) • American Medical Association Current Procedural Terminology (AMA/CPT) codebook

Policy Owner Review	Payment Integrity Oversight Committee
Contact	Any questions regarding the contents of this policy or its application should be directed to the Payment Integrity Department
Annual Review Dates	03/12/26; 11/04/25; 10/07/25; 11/12/24; 05/14/24; 09/06/23; 10/13/22; 11/01/21; 12/30/20; 01/10/20; 02/18/19; 02/27/18; 04/11/17; 05/23/16; 10/25/15; 11/25/14;

	12/15/13; 02/11/13; 11/05/12; 11/04/11; 01/27/11; 03/04/10; 11/22/09; 01/27/09; 10/18/08; 08/04/08; 09/24/07; 04/07/06; 02/28/06; 11/30/05; 08/29/05; 12/17/04; 10/08/04; 11/07/03; 01/09/03; 05/01/00	
Version History	02/27/18	Added Codes/Coding Guidelines section
	02/18/19	• Added a reference to the "Anesthesia Modifiers" Payment Policy in the Anesthesia Modifiers section of the Policy statement. • Added the Obstetrical Anesthesia CPT code to the Codes/Coding Guidelines section
	01/10/20	Annual review; no changes
	12/30/20	• Clarified in the Purpose statement that the policy applies to professional services billed on a CMS-1500 or 837P claim form. • Minor modifications made to the Modifiers section of the Policy statement. • Added list of Anesthesia Modifiers to the Codes/Coding Guidelines section which are appended to identify the level of provider rendering the anesthesia service.
	11/01/21	Annual review; no changes
	10/13/22	• In the Cross Reference section, Modifier 22 payment policy is added. • In the Modifier section, added a paragraph to indicate Modifier 22 is not appropriate to append to anesthesia codes for increased anesthesia service. • In the Moderate/Conscious Sedation section, the descriptions of moderate sedation to be more reflective of the actual code descriptions.
	09/06/23	Annual review; no changes
	05/14/24	• In the Policy statement under the Related Services section, the first paragraph added to indicate that an E&M service one day preoperatively, on the same day of or one day postoperatively to an anesthesia service is included in the anesthesia service. • In the Codes/Coding Guidelines section, added last paragraph on how to report anesthesia when multiple anesthesia procedures are performed.
	11/12/24	In the Exception section of the policy, identified that effective November 24, 2024, procedure code 01996 does not require an anesthesia modifier.
	10/07/25	• Added modifier specific details from the archived Anesthesia modifier policy. • Removed archived Anesthesia Modifier policy from cross reference section.
	11/04/25	Added reimbursement statement for modifier QZ within the policy section: "Effective dates of service on and after **March 6, 2026**, reimbursement will change from 100% to 85% of the provider's applicable Fee Schedule allowed amount.
	03/12/26	Added Modifier 23 details, Modifier 23 policy is archived effective April 2, 2026.