

# Anesthesia

**Origination Date: 09/01/2015**

**Last Review: 10/01/2025**

**Update Notification: 11/01/2025**

**Effective Date: 12/01/2025**

## Description

Anesthesia is the administration of a drug or anesthetic agent by an anesthesiologist or Certified Registered Nurse Anesthetist (CRNA) for medical or surgical purposes to obtain muscular relaxation, induce partial or total loss of sensation and/or consciousness. This policy describes reimbursement for anesthesia services.

## Policy

This Anesthesia policy is developed in part using the Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) Policy Manual, CMS NCCI edits and the CMS National Physician Fee Schedule, American Society of Anesthesiologists (ASA) guidelines, and Oscar's policies regarding the coding of claims. All services described in this policy may be subject to additional Oscar reimbursement policies.

## Reimbursement Guidelines

Oscar reimburses anesthesia based on the concepts of base values, time unit values, and conversion factors. Base values are defined by the ASA and time units are calculated on a 15 minute interval basis and rounded to the nearest decimal point (e.g. 32 minutes of anesthesia equals 2.1 time units). Conversion factors are either explicitly listed in provider contracts or based on CMS localities. Anesthesia time starts when the anesthesiologist begins to prepare the patient for induction and ends when the patient can safely be placed under postoperative supervision.

The following Standard Anesthesia Formula is used to determine anesthesia reimbursement:

$$(\text{Base Value} + \text{Time Units} + \text{Modifying Units}) \times \text{Conversion Factor} = \text{Reimbursement}$$

## Anesthesia Modifiers

The following modifiers should also be applied to distinguish when services are or are not directly performed by an anesthesiologist:

Type of Provider	Modifier	Description	Payment
Anesthesiologist	AA	Anesthesia services performed personally by an anesthesiologist	100% of fee schedule based on appropriate unit rate, unless otherwise specified by state
	AD	Medical supervision for more than four concurrent anesthesia procedures is provided	Reimbursed at a rate equal to three base value units, unless otherwise specified by state
	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, unless otherwise specified by state. (Note: the teaching anesthesiologist must bill with the "AA" modifier in the first field and the "GC" certification modifier in the second field.)
	QK	Medical direction of two, three or four concurrent anesthetic procedures involving qualified individuals (e.g., CRNAs or residents)	Allows 50% of fee schedule payment based on the appropriate unit rate, unless otherwise specified by state
	QY	Anesthesiologist medically directed one CRNA	Allows 50% of fee schedule payment based on the appropriate unit rate, unless otherwise specified by state
CRNA	QZ	CRNA performed services without medical direction	100% of fee schedule based on appropriate unit rate, unless otherwise specified by state
	QX	CRNA performed services under the medical direction of an anesthesiologist	Allows 50% of fee schedule payment based on the appropriate unit rate, unless otherwise specified by state

Supervision vs. Direction

Medical direction occurs when an anesthesiologist directs the delivery of anesthesia care from up to four CRNAs doing concurrent cases. To achieve medical direction, the anesthesiologist must meet seven billing requirements. Documentation must include the following to meet medical direction requirements.

- Perform a pre-anesthetic examination and evaluation
- Prescribe the anesthesia plan
- Personally participate in the most demanding procedures in the anesthesia plan, including induction and emergence
- Ensure a qualified individual performs any procedures in the anesthesia plan that the anesthesiologist does not personally perform
- Monitor the course of anesthesia administration at frequent intervals
- Remain physically present for all key and critical portions of the procedure and be available for immediate diagnosis and treatment of emergencies
- Provide post-anesthesia care as indicated

Medical supervision applies when a physician is overseeing more than four CRNAs who are concurrently administering anesthesia care. There are no requirements for the physician to provide hands-on care; instead, the physician is available to assist in any of the concurrent cases.

Physical Status Modifiers

Physical Status Modifiers for anesthesia are codes that indicate the health condition of a patient undergoing anesthesia. The American Society of Anesthesiologist (ASA) developed the following modifiers to be used to identify the level of complexity of the anesthesia procedure:

Modifier	Description	Modifying Units
P1	A physical status modifier for a normal healthy patient.	0 Units
P2	A physical status modifier for a patient with mild systemic disease.	0 Units
P3	A physical status modifier for a patient with severe systemic disease.	1 Unit
P4	A physical status modifier for a patient with severe systemic disease that is a constant threat to life.	2 Units
P5	A physical status modifier for a patient with severe systemic disease that is a constant threat to life.	3 Units
P6	A physical status modifier for a declared brain-dead patient whose organs are being removed for donor purposes.	0 Units

Qualifying Circumstances

Consistent with CMS, Oscar does not allow separate reimbursement outside of the primary anesthesia code. These codes are assigned a status indicator of "B" (bundled code) on the CMS Physician Fee schedule and are not eligible for separate reimbursement under Medicare guidelines. As per CMS, the value for the qualifying circumstances has already been included in the RVUs for the primary anesthesia procedure codes. Payment for these services is always included in payment for other services not specified. There are no RVUs or payment amounts for these codes and separate payment is not made.

The following Qualifying Circumstances Codes are not reimbursable:

CPT Code	Description
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)
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### Multiple Anesthesia Services

According to the ASA, when multiple surgical procedures are performed during a single anesthesia administration, only the single anesthesia code with the highest Base Unit Value is reported. The time reported is the combined total for all procedures performed on the same patient on the same date of service by the same or different physician or Other Qualified Health Care Professionals (QHP). Add-on anesthesia codes (01953, 01968 and 01969) are exceptions to this. Oscar aligns with these ASA coding guidelines. Specific reimbursement percentages are based on the anesthesia modifier(s) reported.

### Preoperative/Postoperative Visits

Consistent with CMS, Oscar will not separately reimburse an E/M service; CPT codes 99091, 99202-99499 (excluding critical care CPT codes 99291-99292) and 92004-92014 when reported by the Same Specialty Physician or Other QHP on the same date of service as an anesthesia service.

### Transesophageal Echocardiography

Transesophageal Echocardiography (TEE) placement and interpretation is not considered for separate reimbursement in addition to payment for the primary anesthesia procedure. However, when this service is performed for diagnostic purposes and documentation is provided to include a formal report, this service may be considered for separate reimbursement in accordance with CMS guidelines.

### Bundled Services

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. Oscar aligns with the NCCI program, which contains many edits bundling standard preparation, monitoring, and procedural services into anesthesia CPT codes. Examples of integral services include, but are not limited to, the following:

- Transporting, positioning, prepping, draping of the patient for satisfactory anesthesia induction/surgical procedures.
- Placement of external devices including, but not limited to, those for cardiac monitoring, oximetry, capnography, temperature monitoring, EEG, CNS evoked responses (e.g., BSER), and Doppler flow.
- Placement of peripheral intravenous lines for fluid and medication administration.
- Placement of airway (e.g., endotracheal tube, orotracheal tube).
- Laryngoscopy (direct or endoscopic) for placement of airway (e.g., endotracheal tube).
- Placement of nasogastric or orogastric tube.
- Intra-operative interpretation of monitored functions (e.g., blood pressure, heart rate, respirations, oximetry, capnography, temperature, EEG, BSER, Doppler flow, CNS pressure).
- Interpretation of laboratory determinations (e.g., arterial blood gases such as pH, pO<sub>2</sub>, pCO<sub>2</sub>, bicarbonate, CBC, blood chemistries, lactate) by the anesthesiologist/CRNA.
- Nerve stimulation for determination of level of paralysis or localization of nerve(s). (Codes for 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.

### Obstetric Anesthesia

Oscar will reimburse neuraxial labor analgesia based on Base Value plus Time Units, subject to a cap of minutes unless otherwise specified by state. Modifying Units for physical status modifiers will be considered in addition to the Base Value for labor or delivery anesthesia services in accordance with the Standard Anesthesia Formula listed above.

- 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

**Non-Timed Services**

CPT codes 01953 and 01996 are not considered anesthesia services because, according to the ASA, they should not be reported as time-based services.

**Related Policies**

Modifier Guidelines

Bundled Services

**References**

1. American Medical Association, Current Procedural Terminology (CPT®)
2. American Society of Anesthesiologists (ASA)
3. Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services
4. Centers for Medicare and Medicaid Services, National Correct Coding Initiative (NCCI) publications

**Publication History**

Date	Action/Description
09/01/2015	Original Documentation
10/05/2015	Approval and inclusion in Oscar Provider Manual
03/07/2016	Policy Updated
07/20/2017	Policy Updated
05/29/2025	Annual Review; Format Updated to include dates at the top for easier reference, added Description section, added Reimbursement Guidelines section, moved the information from the Policy section into Reimbursement Guidelines Section, added information to the policy section to provide details around development of the policy, added a subheading for Anesthesia Modifiers and moved the modifier table for Anesthesiologists and CRNAs into that section, also added an Obstetric Anesthesia subheading for the neuraxial/epidural labor information already in the policy, added subheadings and information for Supervision vs. Direction, Physical Status Modifiers, Qualifying Circumstances, Multiple Anesthesia Services, Peroperative/Postoperative Visits, Transesophageal Echocardiography, Bundled Services, and Non-Timed Services, added Related Policies and References sections.
10/01/2025	Off-cycle verbiage update. Added "unless otherwise specified by state" to payment descriptions and to Obstetric Anesthesia section.