Keystone First
Family of Health Plans

Anesthesia

Reimbursement Policy ID: RPC.0028.PA01

Recent review date: 12/2025

Next review date: 11/2026

Keystone First VIP Choice 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. Keystone First VIP Choice 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 rendered in conjunction with surgical and diagnostic procedures.

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

In accordance with ASA RVG, anesthesia services reported with CPT codes in range [00100-01999] are reimbursed based on units of time calculated as follows: (Base units + Time units + Modifying units) x Conversion factor = Anesthesia charge.

Required Anesthesia Modifiers
All anesthesia services, including monitored anesthesia care, must be reported with a required anesthesia modifier in the primary position. These modifiers identify whether the procedure was personally performed, medically directed, or medically supervised by an anesthesiologist, Certified Registered Nurse Anesthetist (CRNA), or Anesthesiologist Assistant (AA).

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

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
P1 - Normal healthy patient	0
P2 - Patient with mild systemic disease	0
P3 - Patient with severe systemic disease	1
P4 - Patient with severe systemic disease that is a constant threat to life	2
P5 - Moribund patient who is not expected to survive without the operation	3
P6 - A declared brain-dead patient whose organs are being removed for donor purposes	0

Informational Modifiers
When anesthesia and pain management services are reported with CPT modifiers 23 or 47 or HCPCS modifiers GC, G8, G9 or QS, 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 Keystone First VIP Choice 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, Keystone First VIP Choice requires time-based anesthesia services to 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.

Obstetric Anesthesia
Anesthesia units for labor and delivery are calculated using the above ASA-RVG formula and should be reported with the applicable procedure code(s).

CPT Code	Code Description
01960	Anesthesia for vaginal delivery only
01961	Anesthesia for cesarean delivery only
01967	Neuraxial labor analgesia/analgesia for planned vaginal delivery
+01968	Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia (List separately in addition to primary procedure)
+01969	Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed)

Procedures with an Inherent Anesthesia Component
Certain procedures include an anesthesia component (e.g., diagnostic colonoscopy). Anesthesia services are not separately reimbursable when reported with these procedures. Anesthesia providers should reference CPT and HCPCS procedure code definitions and current NCCI Procedure-to-Procedure files when billing for their services.

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

Definitions

Allowable Amount
The dollar amount eligible for reimbursement to the physician or Other Qualified Health Care Professional on the claim. The Allowed Amount may be the contracted rate, reasonable charge, or billed charges whichever is applicable. For percentage of charge or discount contracts, the Allowable Amount is determined as the billed amount, less the discount.

Anesthesia Professional
An Anesthesiologist is a physician specializing in perioperative care, developing anesthetic plans, and the administration of anesthetics. Certified Registered Nurse Anesthetist (CRNA), Anesthesia Assistant (AA), or other qualified individuals may work independently or under the medical supervision of an anesthesiologist.

Anesthesia Time
Anesthesia Time involves the continuous period that begins when the anesthesia provider prepares the patient for the induction of anesthesia in the operating room or in an equivalent area and ends when the anesthesia professional is no longer in personal attendance and the patient may be safely placed under postoperative supervision.

Base Unit Value
The number of units which represent the Base Value (per code) of all usual anesthesia services, except the time spent in anesthesia care.

Base Value
The Base Value includes preoperative and postoperative visits, the administration of fluids and/or blood products incident to the anesthesia care, and interpretation of non-invasive monitoring (ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry). Placement of arterial, central venous and pulmonary artery catheters and use of transesophageal echocardiography (TEE) are not included in the Base Value.

Moderate Sedation
Moderate (conscious) Sedation is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. Moderate Sedation CPT codes are 99151-99153, 99155-99157.

Monitored Anesthesia Care
Per the ASA Monitored Anesthesia Care includes all aspects of anesthesia care – a preprocedural visit, intraprocedural care and post procedure anesthesia management. Monitored Anesthesia Care may include varying levels of sedation, analgesia and anxiolysis as necessary. Modifiers G8, G9 and QS are used to identify Monitored Anesthesia Care.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. Centers for Medicare and Medicaid Services (CMS).
V. The National Correct Coding Initiative (NCCI).
VI. American Society of Anesthesiologists Relative Value Guide® (ASA-RVG).
VII. Centers for Medicare and Medicaid Services (CMS) NCCI Policy Manual, Chapter 2, CPT codes 00000-01999: https://www.cms.gov/files/document/02-chapter2-ncci-medicare-policy-manual-2025finalcleanpdf.pdf.
VIII. Corresponding Keystone First VIP Choice Clinical Policies.
IX. Applicable Keystone First VIP Choice provider manual reference.
X. CMS Medicare program fee schedule(s).

Attachments

N/A

Associated Policies

RPC.0033.PA01 Multiple Procedure Payment Reduction
RPC.0068.PA01 Obstetrics

Policy History

12/2025	Reimbursement Policy Committee Approval
11/2025	Annual policy review • Reimbursement Guidelines updated with sections for Obstetric Anesthesia and Procedures with an Inherent Anesthesia Component. • Added policy definitions • Updated Edit Sources • Updated Associated Policies section
06/2025	Minor updates to formatting and syntax
11/2025	Reimbursement Policy Committee Approval
04/2025	Revised preamble
12/2024	Reimbursement Policy Committee Approval
11/2024	Annual Review • No major changes
04/2024	Revised preamble
01/2024	Reimbursement Policy Committee Approval
08/2023	Removal of policy implemented by Keystone First VIP Choice 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