curative

TITLE:	ANESTHESIA SERVICES
DEPARTMENT:	PAYMENT POLICY
ORIGINAL EFF. DATE:	12/15/2025
REVISION DATE:	N/A

1. PURPOSE

This Payment Policy outlines clear and consistent reimbursement guidelines to ensure compliant, transparent, and timely payment for medically necessary, cost-effective care.

2. SCOPE

This policy applies to the reimbursement of covered services for all members and providers. Curative will allow reimbursement for services according to the criteria outlined in this policy, unless modified or superseded by contractual language.

3. DEFINITIONS

The following terms are defined as follows regarding this P&P.

3.2 **Qualified Nonphysician Anesthetist** Providers with credentials of a Certified Registered Nurse Practitioner (CRNA) or an Anesthetist Assistant (AA).

3.3. **Same Individual Provider** The Same Individual Physician or Other Qualified Health Care Professional rendering health care services reporting the same Federal Tax Identification number

3.4. **Same Specialty Provider** Physicians and/or Other Qualified Health Care Professionals of the same group and same specialty reporting the same Federal Tax Identification number.

4. POLICY

Disclaimer: These Payment Policies serve as a comprehensive guide for all providers, assisting in submitting accurate claims and outlining the essential framework for reimbursement. The determination that a service, procedure, or item is covered under a Curative member's benefit plan does not constitute a guarantee of payment. Services must meet medical necessity and authorization guidelines appropriate to the procedure and diagnosis and, where mandated, the members state of residence. Services rendered must be within the legal scope of practice for the specific type of provider and align with the professional credentials and training in the state where the care is furnished.

To ensure proper processing, providers are required to adhere to industry-standard, compliant codes and follow proper coding, billing, and submission guidelines. To ensure accurate reimbursement and proper claims adjudication, all services provided to the same member, by the same provider, and on the same date of service must be reported on a single claim. Current Procedure Terminology (CPT®*) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or relevant revenue codes must be used for billing. Codes submitted must be fully supported by corresponding documentation in the medical record. Unless noted otherwise within a policy, these payment policies apply to both participating and non-participating providers and facilities.

Curative reserves the right to take corrective action, which may include the rejection or denial of the claim, or the recovery and/or recoupment of any previous claim payment if proper coding, billing guidelines, or these established payment policies are not followed. Providers may refer to the Provider Manual for guidance on

addressing such actions, including the formal claim reconsideration, appeals, and dispute resolution processes.

These policies may be superseded by mandates within provider contracts, state or federal laws, or requirements issued by the Centers for Medicare & Medicaid Services (CMS). Curative retains the right to revise these policies as deemed necessary and will publish the most current version on the Curative website.

Reimbursement Guidelines

Anesthesia services referred to in this policy include all services typically associated with administering and monitoring general anesthesia, regional anesthesia, monitored anesthesia care (MAC), or other appropriately furnished services reported on a CMS1500 claim form or its electronic equivalent. Curative bases reimbursement for anesthesia services consistent with guidance from the Centers for Medicare & Medicaid Services (CMS), the Current Procedure Terminology (CPT), American Society of Anesthesiologists (ASA), and other medical society standards.

Anesthesia codes considered time based in the CPT section 00100- 01999 will be eligible for reimbursement based on this policy. Claims may be processed according to “same individual physician or other qualified health care professional” or the “same specialty physician or other qualified health care professional” definitions.

The calculation of anesthesia services reimbursement is based on several factors such as base units, time units, modifiers and conversion factors. The base units assigned to the appropriate anesthesia code and utilized by CMS will be used in the reimbursement calculation. Continuous time of provider personal attendance between start and stop of the anesthesia is considered “total time”. It includes when preparation for anesthesia administration begins and it ends when the provider is no longer in personal attendance and the patient is safely placed under postoperative care. Total time should be reported in one-minute increments. This amount is then used to calculate time units by dividing it by 15 to determine the number of 15-minute time units. CPT codes 01953 and 01996 are not time-based codes.

Example: Method for calculating reimbursement for times anesthesia procedures

Scenario:

Conversion Factor= $30.00

Base unit = 4

Time units = 132 minutes (2 hours, 12 minutes)

Reimbursement Calculation:

(Base Unit Value + Time Units) X Conversion Factor

132 Minutes / 15 = 8.8 Time Units

4 Base Units + 8.8 Time Units = 12.8 Total Units

CF $30 X 12.8 Units = $384

Anesthesia Modifiers

Anesthesia Modifiers are required and used to communicate who performed the anesthesia service and their level of involvement. Providers may personally perform services or be medically directed. Anesthesia services will not be reimbursed if an anesthesia modifier is not present. The calculation of the reimbursement is adjusted according to the below percentages. The anesthesia modifier is required to be billed in the first position of the modifier fields.

Anesthesia Modifiers

AA Anesthesiologist Personally Performed 100%

AD Anesthesiologist Supervision over 4 concurrent anesthesia procedures 50%

QK Anesthesiologist MD Direction of 2, 3, or 4 concurrent anesthesia procedures 50%

QS Monitored Anesthesia Care (MAC) performed by a Qualified Nonphysician Anesthetist or physician 50%

QX Qualified Nonphysician Anesthetist with medical direction by anesthesiologist 50%

QY Anesthesiologist MD Direction of 1 Qualified Nonphysician Anesthetist 50%

QZ Certified Registered Nurse Anesthetist (CRNA) Personally Performed 100%

Physical Status Modifiers

Curative does not allow additional reimbursement for physical status modifiers. Physical status modifiers are informational only.

Qualifying Circumstances Codes

Curative does not allow additional reimbursement for qualifying circumstances codes. Qualifying circumstances codes are informational only.

Surgical Pain Blocks

Pain blocks are placed before induction of anesthesia or after the patient emerges from the effects of anesthesia. Time spent placing the block is not reimbursable as an anesthesia service and is not added to the reported anesthesia time.

Anesthesia for Pain Management Injections

Minor pain management procedures, including but not limited to, epidural steroid injections, trigger point injections, and epidural blood patch, usually only require local anesthesia. For adults, an accompanying surgical procedure (other than a pain management procedure) must also be present on the claim for the associated anesthesia and moderate sedation service to be eligible for reimbursement.

Conscious or Moderate Sedation

Curative does not allow separate reimbursement for local anesthesia or for anesthesia administered by the operating surgeon, surgical assistant, or dentist. This is considered incidental to the surgical or dental procedure. This includes sedation given for endoscopic procedures including colonoscopy.

Note: Dental anesthesia must be reported using the appropriate ADA dental anesthesia code, not as an anesthesia CPT procedure.

Anesthesia Supplies and Bundled Services

Curative does not allow additional reimbursement for anesthesia supplies incidental to the anesthesia service codes (00100 - 01999). Services with CMS National Physician Fee Schedule status indicator B, bundled code or T Injections are not reimbursed separately. Evaluation and Management services, excluding Critical Care, will not be reimbursed on the same date as an anesthesia service when reported by the same specialty physician or other qualified healthcare professional of the same group and same specialty reporting the same federal tax identification number.

Obstetrical Anesthesia

Obstetrical anesthesia services are not time-based services. To identify who performs the service and their level of involvement, the anesthesia modifiers are still required to be applied.

Obstetrical services include:

- Anesthesia for vaginal delivery
- Neuraxial labor analgesia/anesthesia for planned vaginal delivery
- Daily hospital management of epidural or subarachnoid continuous drug administration

Multiple General Anesthesia Services

Curative only allows reimbursement for one timed anesthesia procedure code per date of service by the same or different provider. When multiple general anesthesia services are performed on the same date of service, only the anesthesia code with the highest base value that correlates to the procedure performed should be reported. Time units reported should be combined and identify the time for all anesthesia services performed on the same date of service.

Duplicate Anesthesia Services

If duplicate claims are submitted by the same or different individual physician or other qualified health care professional for the same patient on the same date of service, only the first submission will be considered for reimbursement.

Anesthesia administration services can be rendered simultaneously by an MD, and a CRNA are not considered duplicate services during the same operative session. These services should be identified by use of modifiers QK, QY or QX as appropriate. Reimbursement for these services are described above in the Anesthesia Modifiers section.

Anesthesia services for two separate operative sessions on the same date can be identified using the appropriate modifier such as 59, 77, 78, 79, or XE. As with the initial anesthesia administration, only the single anesthesia code with the highest Base Unit Value should be reported.

5. REFERENCE DOCUMENTS AND MATERIALS

5.1 American Medical Association, Current Procedural Terminology (CPT®) and associated publications and services

5.2. Centers for Medicare and Medicaid Services, Healthcare Common Procedure

5.3. Centers for Medicare and Medicaid Services, National Correct Coding Initiative (NCCI) publications

5.4. Centers for Medicare and Medicaid Services (CMS), Physician Fee Schedule (PFS) Relative Value Files

5.5. National Uniform Claim Committee (NUCC)

6. COLLABORATING DEPARTMENTS

6.1. Claims

6.2. Compliance

6.3. Medical Management

6.4. Network

6.5. System Configuration

7. POLICY & PROCEDURE CONTROL

This Policy will be reviewed at least annually and as necessary.

REVISION HISTORY			
Date	**Author**	**Version**	**Comments**
12-15-2025	CJ Wisecarver	001	Initial Version