Summit COMMUNITY CARE

Arkansas | Medicaid

Reimbursement Policy
Anesthesia Services

Policy Number: **G-07018**
Policy Section: **Anesthesia**
Last Approval Date: **01/26/2026**
Effective Date: **01/26/2026**

Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **https://provider.summitcommunitycare.com**.

Policy

The health plan allows reimbursement of anesthesia services rendered by professional providers for covered members unless provider, state, federal, or CMS contracts and/or requirements indicate otherwise.

Reimbursement is based upon:

- The reimbursement formula for the allowance and time increments in accordance with CMS guidelines.
- Proper use of applicable modifiers.

Providers must report anesthesia services in minutes. Anesthesia claims submitted with an indicator other than minutes may be rejected or denied. Start and stop times must be documented in the member's medical record. Anesthesia time starts with the preparation of the member for administration of anesthesia and stops when the anesthesia provider is no longer in personal and continuous attendance. The reimbursement formula for anesthesia allowance is based on CMS guidelines, unless otherwise noted in the exemption section.

The health plan requires anesthesia services to be billed with the number of units specified in the unit field for paper claims. Each fifteen (15) minutes of anesthesia corresponds to one (1) time unit. For electronic claims, the total minutes must be submitted in the unit field.

Anesthesia modifiers

Anesthesia modifiers are appended to the applicable procedure code to indicate the specific anesthesia service or who performed the service. Modifiers identifying who performed the anesthesia service must be billed in the primary modifier field to receive appropriate reimbursement. Additional or reduced payment for modifiers is based on state requirements, as applicable. If there is no state requirement, the health plan will default to the following CMS guidelines. Claims submitted for anesthesiology services without the appropriate modifier will be denied. Please review the Related Coding section below for reimbursement information for specific anesthesia modifiers.

Multiple anesthesia procedures
The health plan allows reimbursement for professional anesthesia services during multiple procedures. Reimbursement is based on the anesthesia procedure with the highest base unit value and the overall time of all anesthesia procedures.

Obstetrical anesthesia
The health plan allows reimbursement for professional neuraxial epidural anesthesia services provided in conjunction with labor and delivery for up to 300 minutes by either the delivering physician or a qualified provider other than the delivering physician, based on the time the provider is physically present with the member. Providers must submit additional documentation upon dispute to be considered for reimbursement for time exceeding 300 minutes. Reimbursement is based on one of the following:

- For the delivering physician — based on a flat rate or fee schedule using the surgical CPT® pain management codes for epidural analgesia.
- For a qualified provider other than the delivering physician — based on:
  - The allowance calculation.
  - The inclusion of catheter insertion and anesthesia administration.

Services provided in conjunction with anesthesia
The health plan allows separate reimbursement for the following services provided in conjunction with the anesthesia procedure or as a separate service:

- Swan-Ganz catheter insertion.
- Central venous pressure line insertion.
- Intra-arterial lines.
- Emergency intubation (must be provided in conjunction with the anesthesia procedure to be considered for reimbursement).
- Critical care visits.
- Transesophageal echocardiography.

Note: Reimbursement is based on the applicable fee schedule or contracted/negotiated rate, with no reporting of time.

Nonreimbursable
The health plan does not reimburse for:

- Anesthesia consultations on the same date as surgery or the day prior to surgery if part of the preoperative assessment.
- Anesthesia services performed for non-covered procedures, including services considered not medically necessary, experimental, and/or investigational.
- Anesthesia services by the provider performing the basic procedure, except for a delivering physician providing continuous epidural analgesia.
- Local anesthesia considered incidental to the surgical procedure.
- Standby anesthesia services.

Reimbursable
The health plan allows reimbursement for qualifying circumstances codes denoting additional complexity levels for a patient of extreme age.

The health plan allows additional reimbursement for the following physical status modifiers:

- Modifier P1: a normal, healthy patient.
- Modifier P2: a patient with mild systemic disease.
- Modifier P3: a patient with severe systemic disease.
- Modifier P4: a patient with a severe systemic disease that is a constant threat to life.
- Modifier P5: a moribund patient who is not expected to survive without the operation.

Related Coding

- Modifier AA – Anesthesia services personally performed by the anesthesiologist
  - Reimbursed at 100% of applicable fee schedule or contracted/negotiated rate
- Modifier AD – Medical supervision by a physician: more than four (4) concurrent anesthesia procedures
  - Reimbursed at 100% of the applicable fee schedule or contracted/negotiated rate for up to three base units for anesthesiologists
- Modifier QK – Medical direction of two, three, or four concurrent anesthesia procedures involving qualified people
  - Reimbursed at 50% of allowance. Reimbursement is based on 50% of the applicable fee schedule or contracted/negotiated amount
- Modifier QX – Qualified nonphysician anesthetist with medical direction by a physician
  - Reimbursed at 50% of the applicable fee schedule or contracted/negotiated amount
- Modifier QY – Anesthesiologist medically directs one CRNA
  - Reimbursed at 50% of the applicable fee schedule or contracted/negotiated amount
- Modifier QZ – CRNA without medical direction by a physician
  - Reimbursed at 100% of the applicable fee schedule or contracted/negotiated amount
- Modifier 23 – Denotes a procedure that must be done under general anesthesia due to unusual circumstances, although normally done under local or no anesthesia
  - Reimbursed at 100% of the applicable fee schedule or contracted/negotiated rate of the procedure. Does not increase or decrease reimbursement; it substantiates billing for anesthesia associated with the procedure in cases where anesthesia is not usually appropriate
- Modifier 47 – Denotes regional or general anesthesia services provided by the surgeon performing the medical procedure. We do not allow reimbursement of anesthesia services by the provider performing the medical procedure (other than obstetrical — see Obstetrical Anesthesia section of this policy); therefore, it is not appropriate to bill Modifier 47 with anesthesia services
  - No additional reimbursement is allowed for anesthesia services by the provider performing the medical procedure (other than obstetrical — see Obstetrical

Anesthesia section of this policy); therefore, it is not appropriate to bill Modifier 47 with anesthesia services

Definitions

- **Anesthesia -** Refers to the drugs or substances that cause a loss of consciousness or sensitivity to pain.
- **Base unit -** The relative value unit associated with each anesthesia procedure code as assigned by CMS.
- **Time unit -** An increment of fifteen (15) minutes where each 15-minute increment constitutes one (1) time unit.
- **Conversion factor -** A geographic-specific amount that varies by the locality where the anesthesia is administered.
- **General Reimbursement Policy Definitions**

Related Policies and Materials

- Maternity Services
- Modifier Usage
- Modifiers 52, 53, 73, and 74: Reduced and Discontinued Services

References and Research Materials

This policy has been developed through consideration of the following:

- American Society of Anesthesiologists
- CMS
- Optum EncoderPro 2025
- State contract
- State Medicaid

Policy History

- **01/26/2026 -** Review approved and effective: updated language to require anesthesia services to be billed with the number of units specified in the unit field for paper claims. Each fifteen (15) minutes of anesthesia corresponds to one (1) time unit. For electronic claims, the total minutes must be submitted in the unit field)
- **11/14/2025 -** Review approved and effective: no changes
- **06/13/2023 -** Review approved and effective: updated policy template; updated policy language to allows reimbursement for qualifying circumstances codes denoting additional complexity levels for a patient of “extreme age”
- **10/01/2021 -** Update due to regulatory: added language that providers must bill in units when submitting paper claims
- **11/06/2020 -** Review approved and effective: minor administrative updates, added grids for anesthesia modifier and reimbursement formulas
- **03/01/2019 -** Initial approval and effective

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by a member’s benefit plan. The determination that a service, procedure, or item is covered

under a member's benefit plan is not a determination that you will be reimbursed. Services must also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member’s state of residence.

Ensure that you use proper billing and submission guidelines, including industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedural Terminology (CPT®) codes, Healthcare Common Procedure Coding System (HCPCS) codes, and/or revenue codes. These codes denote the services and/or procedures performed and, when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, we may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, we will publish the most current policy to the website.

©2019-2026 Summit Community Care. All Rights Reserved.