Reimbursement/Billing Policy

PARAMOUNT

HMO AND PPO
ELITE (MEDICARE ADVANTAGE)
MARKETPLACE

Anesthesia Qualifying Circumstances

Policy Number: RM041
Last Reviewed Date: 07/01/2025
Last Revised: 07/01/2025

GUIDELINES:

- Paramount Reimbursement Policies have been developed to assist in administering proper payment under benefit contracts.
- Reimbursement policies may be superseded by mandates in provider, state, federal, or CMS contracts and/or requirements.
- Paramount utilizes industry standard coding methodology and claims editing in the development of reimbursement policies. Industry standard resources include, but are not limited to, CMS National Correct Coding Initiative (NCCI), Medically Unlikely Edits (MUEs), Integrated Outpatient Code Editor (I/OCE) Clinical edits, Medical Policies, Reimbursement Policies, and Administrative/Provider Manuals. Paramount will not reimburse services determined to be Incidental, Mutually Exclusive, or Unbundled.
- All health care services, devices, and pharmaceuticals must be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes and modifiers, which most accurately represent the services rendered, unless otherwise directed by the Paramount. All billed codes must be fully supported in the member's legal medical record.
- Paramount utilizes CMS pricing algorithms where appropriate based on, National Physician Fee Schedule Relative Value File (NPFSRVF) pricing rules, Inpatient Prospective Payment Systems (MS-DRG, LTC, IPF, IRF & IPSNF) and Outpatient Prospective Payment Systems (OPPS, HHA, ASC, ESRD & OPSNF).
- Paramount liability will be determined after coordination of benefits (COB) and third-party liability (TPL) is applied to the claim. Member liability may include, but is not limited to, co-payments, deductibles, and coinsurance. Members' costs depend on member benefits.
- Paramount routinely reviews reimbursement policies. Updates are published on Paramount's website https://www.paramounthealthcare.com. The information presented in this reimbursement policy is accurate and current as of the date of publication. Paramount communicates policy updates to providers via Paramount's monthly bulletin.

SCOPE:

X Professional
_ Facility

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 relieve pain and/or induce partial or total loss of sensation and/or consciousness during a procedure. A variety of levels of anesthesia exist, ranging from local through general anesthesia. As physicians, anesthesiologists are responsible for administering anesthesia to relieve pain and for managing vital life functions during surgery.

Sometimes anesthesia services are provided under difficult circumstances, which may affect the condition of the patient, or present unusual operative conditions and/or risk factors. In these situations, there are modifiers and/or codes that are reported in addition to the primary anesthesia procedure codes. These qualifiers are called physical status modifiers and qualifying circumstances and are used to indicate that the service provided is greater than what is usually required.

POLICY:

Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans

Paramount Healthcare aligns with CMS and does not recognize or support additional anesthesia reimbursement for the Physical Status (P) modifiers or the Qualifying Circumstances procedure codes.

COVERAGE CRITERIA:

Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans

Reimbursement for qualifying circumstances procedure codes 99100-99140 and modifiers P1-P6 are bundled in the payment for codes 00100-01999, separate reimbursement is not supported.

Physical Status Modifiers:

Modifier	Modifier Description
Modifier P1	A physical status modifier for a normal healthy patient
Modifier P2	A physical status modifier for a patient with mild systemic disease
Modifier P3	A physical status modifier for a patient with severe systemic disease
Modifier P4	A physical status modifier for a patient with severe systemic disease that is a constant threat to life
Modifier P5	A physical status modifier for a moribund patient who is not expected to survive without the operation
Modifier P6	A physical status modifier for a declared brain-dead patient whose organs are being removed for donor purposes
Physical status modifiers identify levels of complexity of the anesthesia services.	
The P-modifiers are reported in conjunction with anesthesia CPT® code (00100-01999) when appropriate.	
Physical status modifiers (P1 through P6) are informational only and not eligible for additional reimbursement when reported	

Qualifying Circumstances for Anesthesia:

Codes	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)
Codes 99100-99140 are add-on codes that include a list of important qualifying circumstances that significantly affect the character of the anesthesia service provided. These circumstances would be reported as additional procedure numbers qualifying an anesthesia procedure or service. More than one code in the section may be selected, if applicable.	
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 amount for these codes and separate payment is not made.	

CODING/BILLING INFORMATION:

The appearance of a code in this section does not necessarily indicate coverage. Codes that are covered may have selection criteria that must be met. Payment for supplies may be included in payment for other services rendered.

CPT CODES	
99100	Patient is extreme age, under one year or over 70 years (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)

REVISION HISTORY EXPLANATION: ORIGINAL EFFECTIVE DATE: 07/01/2025

Date	Explanation & Changes
07/01/2025	• Reimbursement/Billing Policy created

REFERENCES/RESOURCES

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs

National Physician Fee Schedule Relative Value File Calendar Year XXXX, Centers for Medicare & Medicaid Services (CMS) https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files

NCCI Policy Manual for Medicare Services, current version, Chapter 1, General Correct Coding Policies https://www.cms.gov/files/document/medicare-ncci-policy-manual-2023-chapter-1.pdf

American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services https://www.ama-assn.org/amaone/cpt-current-procedural-terminology

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update

Centers for Medicare & Medicaid Services (CMS), ICD-10-CM Official Guidelines for Coding and Reporting https://www.cms.gov/medicare/coding/icd10

Centers of Medicare & Medicaid Services (CMS), Medicare Claims Processing Manual, Chapter 23-Fee Schedule administration and coding Requirements https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf

Centers for Medicare & Medicaid Services (CMS), National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci/ncci-medicare

Center for Medicare and Medicaid Services, Medicare NCCI Medically Unlikely Edits (MUEs) https://www.cms.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medically-unlikely-edits

U.S. Preventive Services Task Force, https://www.uspreventiveservicestaskforce.org/uspstf/
Industry Standard Review

Hayes, Inc., https://www.hayesinc.com/

Industry Standard Review