Harvard Pilgrim Health Care | TUFTS Health Plan

Point32Health companies

Payment Policy:
Anesthesia

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products
☒ Tufts Health Plan Commercial products

Public Plans Products

☒ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product)
☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans
☒ Tufts Health RITogether – A Rhode Island Medicaid Plan
☒ Tufts Health One Care – A dual-eligible product

Senior Products

☒ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)
☒ Tufts Medicare Preferred HMO/PPO (Medicare Advantage products)

Policy

Point32Health reimburses contracted anesthesia providers for the provision of general, regional, or local anesthesia and supportive services.

Prerequisites

Applicable Point32Health referral, notification, and authorization policies may apply. Refer to the appropriate sections within the Provider Manuals for more information.

General Benefit Information

Services are pursuant to the member's benefit plan documents and are subject to applicable member out-of-pocket cost (e.g., copayment, coinsurance, deductible). Member eligibility and benefit specifics should be verified prior to initiating services.

Use of non-contracted labs may have the unintended consequence of subjecting the member to unnecessary services not ordered by the treating provider or other unreasonable financial exposure. In such circumstances, Point32Health may hold the ordering provider accountable for any inappropriate behavior on the part of the nonparticipating lab that has been selected.

Point32Health Reimburses

- Anesthesia services using the American Society of Anesthesiologists (ASA) codes and the Anesthesia Unit System
- The primary anesthesia service with the highest unit value only when multiple surgical procedures are billed during a single anesthetic administration
- Base values as defined by the ASA
- General anesthesia, based on the sum of the allowable base and time units
- General anesthesia for procedures other than surgical (diagnostic tests, exams, etc.) using base plus time methodology
- Insertion of an inter-arterial monitoring line during surgery
- Insertion of a central venous pressure monitoring during surgery
- Transesophageal echocardiography when performed with general anesthesia for monitoring and diagnostic services
- Placement of Swan Ganz catheter
- Monitored anesthesia care
- Radiological services requiring general/regional anesthesia/deep sedation using base plus time methodology
- Discontinuous anesthesia time as long as there is continuous monitoring of the patient within the discontinuous blocks of time

- Medically directed services, as defined by CMS, when billed by an anesthesiologist
- Teaching anesthesiologists for procedures performed by residents in a single anesthesia case, two concurrent anesthesia cases, or a single anesthesia case that is concurrent to another case; documentation in the patient's medical record must indicate the teaching anesthesiologist's presence during all critical or key portions of the anesthesia procedure and immediate availability
- Obstetrical Anesthesia, which includes repeat subarachnoid needle placement and drug injection and /or any necessary replacement of an epidural catheter during labor
- Post-operative or medical pain management services may be reimbursed when:
  - Requested in writing by the ordering physician
  - Patient-controlled analgesia is performed subsequent to the day of surgery
  - Epidural or spinal analgesia is used to manage post-operative pain or a medical diagnosis including:
    - Administration of epidural/spinal analgesia by a single narcotic shot
    - Insertion of an epidural or spinal catheter for continuous post-operative pain management, which includes all narcotic administration on that date
    - An epidural or spinal catheter is placed primarily for post-operative pain control on the day of surgery

Outpatient Pain Management

- Regional blocks or therapeutic injections, when performed by the anesthesiologist at a standard surgical rate methodology
- Trigger point injections
- Fluoroscopic guidance and localization when appropriate
- Outpatient evaluation and management codes

Point32Health Does *Not* Reimburse

- Activities considered part of anesthesia services, including but not limited to:
  - All usual pre- and post-operative services, including evaluation and management services
  - Induction of anesthesia during the procedure
  - Incidental administration of parental fluids and/or blood products
  - Usual monitoring procedures associated with the complexity of the service
- CPT codes designated by the ASA as not normally requiring anesthesia
- Qualifying circumstances for anesthesia
- Ventilation management related to the surgery anesthesia
- Therapeutic services such as pulmonary function testing related to the general anesthesia
- Evaluation and management services for post-operative pain control on the day of the surgery
- Insertion of a catheter on the same day that epidural anesthesia was delivered during surgery, as it is included in the base value of the anesthesia care
- Inpatient pain management services on the same day of service as the insertion of an epidural catheter or single epidural injection
- Anesthesia and moderate sedation services when billed with pain management services and billed without a surgical code by any provider for a member age 18 and older

Tufts Health Plan

- ASA code 00811 when billed with modifier PT, unless a CPT surgery code has been billed for the same date of service by any provider

Provider Billing Guidelines and Documentation

Providers are reimbursed according to the applicable contracted rates and fee schedules. These lists may not be all inclusive.

Moderate Sedation

Code	Description	Comments
G0500	Moderate sedation services provided by the same physician or other qualified health care professional performing a gastrointestinal endoscopic service that sedation supports	Bill with CPT 43200-45398, HCPCS G0105, and G50121
99151-99152	Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the	CPT 99152 may not reimbursed when billed with CPT 43200-45398, HCPCS G0105 and G0121

Code	Description	Comments
	sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status	

Obstetrical

Code	Description	Comments
01960	Anesthesia for vaginal delivery only	Bill when no neuraxial/anesthesia is involved with vaginal delivery; not reimbursed with 01967
01961	Anesthesia for Cesarean delivery only	Use to report anesthesia services for a planned cesarean section; not reimbursed with 01968
01967	Neuraxial labor analgesia/anesthesia for planned vaginal delivery	Use to report epidural labor and vaginal delivery
01968	Anesthesia for cesarean delivery following neuraxial labor/anesthesia (List separately in addition to code for primary procedure performed)	Must be reported in addition to 01967; use to report when a planned vaginal delivery turns into a cesarean section
01969	Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia	Must be reported in addition to 01967; not reimbursed when billed alone

Note: Cap limits may apply.

Modifiers

Code	Description	Comments
AA	Anesthesia services performed personally by anesthesiologist	Reimbursed at 100% of the fee schedule/allowable rate
AD	Medical supervision for more than four concurrent anesthesia	**Harvard Pilgrim Health Care** • Documentation required • Reimbursed at a rate equal to three base units plus one additional unit if the physician was present for intubation **Tufts Health Plan** • Reimbursed at 50% of the fee schedule/allowable rate
G8	Monitored anesthesia care (MAC) for deep, complex, complicated or markedly invasive surgical procedures	Modifier use will not impact reimbursement
G9	Monitored anesthesia care for patient who has history of severe cardiopulmonary condition	Modifier use will not impact reimbursement
GC	This service has been performed in part by a resident under the direction of a teaching physician	• Reimbursed at 100% of the fee schedule/allowable rate when billed by the teaching physician • Modifier AA must be reported in the first field and the certification modifier GC in the second field
P1-P6	Physical status modifiers	• Modifiers are required and should be reported in the secondary position • Modifier use will not impact reimbursement
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals	Reimbursed at 50% of the fee schedule/allowable rate
QS	Monitored anesthesiology care service	Modifier use will not impact reimbursement
QX	CRNA service; with medical direction by a physician	Reimbursed at 50% of the fee schedule/allowable rate
QY	Medical direction of one CRNA by an anesthesiologist	Reimbursed at 50% of the fee schedule/allowable rate
QZ	CRNA service; without medical direction by a physician	Modifier use will not impact reimbursement

Calculating Units

- Documentation must include anesthesia start and stop times

- During claims processing minutes will be converted into time units and reimbursement will be based on the sum of the allowable base and time units
- Maximum units may be applied to anesthesia services

Tufts Health Commercial

- Each 15-minute interval is converted to one time unit, rounding up to the next unit for 8-14 minutes and rounding down for 1-7 minutes

Harvard Pilgrim Health Care Commercial and Senior Products

- Each 15-minute interval is converted to one time unit, rounding to the nearest tenth of a unit (one decimal place)

Tufts Health Public Plans

- Each 15-minute interval is converted to one time unit, or a fraction of 15 minutes equal to or exceeding five minutes, up to 15 minutes

Other Information

- Submit one anesthesia modifier per anesthesia service claim line
- Bill for pre-anesthesia services only when surgery is cancelled after the pre-anesthesia work-up with inpatient consultation codes
- Do not report pain management services with time/minutes

Related Policies and Resources

Payment Policies

- Advanced Practice Provider (APP)
- Evaluation and Management
- Maximum Units
- Non-Covered Services
- Surgery

Clinical Policies

- Implantable Neurostimulators
- Monitored anesthesia Care and Assistance for Gastrointestinal Endoscopic Procedures
- Noncovered Investigational Services

Other Resources

- MassHealth Regulation: 101 CMR 316.00: Surgery and Anesthesia
- Medicare Claims Processing Manual: Chapter 12

Publication History

04/01/2026: Policy moved to new template; includes all lines of business

Background and Disclaimer Information

This policy applies to the products of Harvard Pilgrim Health Care and Tufts Health Plan and their affiliates, as identified in the check boxes on the first page for services performed by contracted providers.

Payment is based on member benefits and eligibility on the date of service, medical necessity review, where applicable, and the provider's network participation agreement with the Plan. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization, and utilization management requirements (when applicable), adherence to Plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment.

Point32Health reserves the right to amend a payment policy at its discretion. CPT and HCPCS codes are updated as applicable; please adhere to the most recent CPT and HCPCS coding guidelines.

We reserve the right to conduct audits on any provider and/or facility to ensure accuracy and compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, Harvard Pilgrim Health Care and Tufts Health Plan will expect the provider/facility to refund all payments related to noncompliance.