Anesthesia Payment Policy

Applies to the following CarePartners of Connecticut products:

☒ CareAdvantage Preferred

☒ CarePartners Access

The following payment policy applies to providers who render anesthesia services to members of the CarePartners of Connecticut plans selected above.

Policy

CarePartners of Connecticut covers anesthesia services, including outpatient pain management, in accordance with the member's benefits.

Referral/Prior Authorization/Notification Requirements

Certain procedures, items and/or services may require prior authorization. While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you must confirm that prior authorization has been obtained. For more information, refer to the CarePartners of Connecticut Provider Manual.

Billing Instructions

Unless otherwise stated, CarePartners of Connecticut follows industry-standard coding guidelines. Refer to current industry-standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers, and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules.

Use of labs not participating in the member's applicable network(s) 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, CarePartners of Connecticut may hold the ordering provider accountable for any inappropriate behavior on the part of the nonparticipating lab that has been selected.

- Submit the total number of minutes to reflect anesthesia services rendered (e.g., submit two hours and ten minutes as 130 minutes). Claims submitted in units will be rejected.
- Report the start and end time for administration of anesthesia.
- If submitting multiple anesthesia services on the same day, submit the primary anesthesia service only with the highest base unit value (BUV). Total time should be submitted for all procedures performed.
- 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.

Anesthesia Time 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

The following formula is used when calculating time units. Each 15-minute interval is converted to one time unit, rounding to the nearest tenth of a unit (one decimal place).

The chart time must be reported when submitting a paper claim to validate the number of minutes billed and the chart time must be reported in the patient's record.

Anesthesia Modifiers

Submit one anesthesia modifier per anesthesia service claim line. Claim lines billed with multiple anesthesia modifiers will be denied.

Modifier	Description	Notes
AA	Anesthesia services personally performed by the anesthesiologist	100% of fee schedule/allowed amount
AD	Supervision, more than four procedures	50% of fee schedule/allowed amount
GC	Services performed by a resident under the direction of a teaching physician	Teaching anesthesiologist should report modifiers AA and GC (certification modifier)
G8	Deep complex complicated, or markedly invasive surgical procedures	Used for reporting purposes only
G9	Appended with an anesthesia code to indicate that the patient has a history of a severe cardiopulmonary condition	Used for reporting purposes only
P1-P6	Physical status modifiers	Report in the secondary modifier position
QK	Medical direction of two, three, or four concurrent anesthesia procedures	50% of fee schedule/allowed amount
QS	Monitored anesthesia care (MAC) services (can be billed by a qualified nonphysician anesthetist or physician)	Used for reporting purposes only
QX	Qualified non-physician anesthetist with medical direction by a physician	50% of fee schedule/allowed amount
QY	Medical direction of one CRNA/AA by an anesthesiologist	50% of fee schedule/allowed amount
QZ	Certified registered nurse anesthetist (CRNA) without medical direction by a physician	100% of fee schedule/allowed amount

Moderate Sedation

Code	Description	Notes
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 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	CPT 99152 may not reimbursed when billed with CPT 43200-45398, HCPCS G0105 and G0121

Compensation/Reimbursement Information

Providers are compensated according to the applicable contracted rates and applicable fee schedules. Compensation for anesthesia services is based on standard CMS and American Society of Anesthesiology method pricing:

[(time units + base unit value) x anesthesia conversion factor]

BUVs will automatically be included in the compensation. Pre- and postoperative consultations are considered part of the BUV.

CarePartners of Connecticut 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 CMS
- 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

CarePartners of Connecticut 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
- 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

Additional Resources

- Advanced Practice Provider (APP)
- Evaluation and Management Professional Payment Policy
- Maximum Units
- Surgery Professional Payment Policy

Document History

- April 2026: Clarified and consolidated existing billing and reimbursement information; administrative updates
- December 2025: Annual review; administrative edit
- January 2025: Annual coding updates; removed end-dated codes 0228T, 0229T, 0230T, 0231T
- December 2024: Annual policy review; updated Additional Resources
- January. 2024: Annual policy review; updated modifier grid; administrative updates
- January 2023: Annual policy review; administrative updates
- March 2022: Coding updates; replaced deleted codes 01935-01936 with codes 01937-01942, effective Jan. 1, 2022
- January 2021: Added edit for maximum anesthesia units, effective for dates of service on or after April 1, 2021
- December 2020: Added applicable CarePartners Access PPO content, effective for dates of service on or after Jan. 1, 2021

- January 2020: Eliminate referral requirements for in-network providers effective Jan. 1, 2020
- November 2019: Policy reviewed by committee; clarified claim submission requirements for reporting anesthesia minutes
- January 2019: Policy created

Audit and Disclaimer Information

CarePartners of Connecticut reserves the right to conduct audits on any provider and/or facility to ensure 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, CarePartners of Connecticut will expect the provider/facility to refund all payments related to noncompliance.

This policy provides information on CarePartners of Connecticut claims adjudication processes. 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. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the CarePartners of Connecticut products identified by the checkboxes on page one. CarePartners of Connecticut reserves the right to amend a payment policy at its discretion.