moda HEALTH	Reimbursement Policy Manual	Policy #:	RPM032
Policy Title:	Anesthesia Physical Status Modifiers (P1 - P6)		
Section:	Anesthesia	Subsection:	Modifiers

Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:

Companies:	☒ All Companies: Moda Partners, Inc. and its subsidiaries & affiliates ☐ Moda Health Plan ☐ Moda Assurance Company ☐ Summit Health Plan ☐ Eastern Oregon Coordinated Care Organization (EOCCO) ☐ OHSU Health IDS
Types of Business:	☒ All Types ☐ Commercial Group ☐ Commercial Individual ☐ Commercial Marketplace/Exchange ☐ Commercial Self-funded ☐ Medicaid ☐ Medicare Advantage ☐ Short Term ☐ Other: _____
States:	☒ All States ☐ Alaska ☐ Idaho ☐ Oregon ☐ Texas ☐ Washington
Claim forms:	☒ CMS1500 ☒ CMS1450/UB (or the electronic equivalent or successor forms)
Date:	☒ All dates ☐ Specific date(s): _____ ☐ Date of Service; For Facilities: ☐ n/a ☐ Facility admission ☐ Facility discharge ☐ Date of processing
Provider Contract Status:	☒ Contracted directly, any/all networks ☒ Contracted with a secondary network ☒ Out of Network

Originally Effective:	1/1/2000	Initially Published:	8/14/2013
Last Updated:	8/14/2024	Last Reviewed:	8/14/2024
Last update includes payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)? No			
Last Update Effective Date for Texas:		8/14/2024	

Reimbursement Guidelines

A. Medicare Advantage plans.

1. Effective for dates of service 7/1/2019 and following, no additional reimbursement will be made for modifiers P1 – P6. This is consistent with original Medicare which does not recognize Physical Status modifiers P1 – P6. [6]
2. Information for dates of service 6/30/2019 and prior has been archived. If this information is needed, please contact our Customer Service team, provide the relevant claim number and date of service and request the archived policy information. A 2019 version of this policy containing the archived information applicable to this time span will be obtained and provided to you.

B. Medicaid plans.

No additional reimbursement is given for modifiers P1 – P6. Reimbursement for modifiers P1 - P6 is bundled in the payment for codes 00100-01999. This policy is sourced to OAR 410-130-0368 – Anesthesia Services, which states:

"(6) Reimbursement for qualifying circumstances codes 99100-99140 and modifiers P1-P6 is bundled in the payment for codes 00100-01999. Do not add charges for 99100-99140 and modifiers P1-P6 in charges for 00100 - 01999." [5]

C. Commercial plans.

1. Additional reimbursement will be allowed for certain physical status modifiers, which is the equivalent of additional anesthesia time at the fee schedule rate, as shown below:

Modifier	Modifier Description & Definition	Physical Status Time Allotment for Reimbursement
P1	A normal healthy patient	None
P2	A patient with mild systemic disease	None
P3	A patient with severe systemic disease	15 minutes
P4	A patient with severe systemic disease that is a constant threat to life	30 minutes
P5	A moribund patient who is not expected to survive without the operation	45 minutes
P6	A declared brain-dead patient whose organs are being removed for donor purposes	None

2. The submission of a physical status modifier appended to an anesthesia procedure code indicates that documentation is available in the patient's records supporting the situation described by the modifier descriptor, and that these records will be provided in a timely manner for review upon request.

3. Appropriate use of physical status modifiers:
   Appended to CPT codes 00100 through 01999 (anesthesia service/procedure codes).

4. Improper use of physical status modifiers:
   a. Appended to CPT codes other than 00100 through 01999 (anesthesia service/procedure codes).
   b. Appending one of these modifiers for a situation other than the one described by the modifier descriptor.

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation	Definition
AMA	American Medical Association
CCI	Correct Coding Initiative (see "NCCI")
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
DRG	Diagnosis Related Group (also known as/see also MS DRG)
HCPCS	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	Health Insurance Portability and Accountability Act
MS DRG	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	National Correct Coding Initiative (aka "CCI")
RPM	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
UB	Uniform Bill

Modifier Definitions:

Modifier	Modifier Description & Definition
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 severe systemic disease that is a constant threat to life
Modifier P5	A moribund patient who is not expected to survive without the operation
Modifier P6	A declared brain-dead patient whose organs are being removed for donor purposes

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

Medicare:

"Physician status (P1-P6) – not recognized by Medicare." [6]

"Medicare does not recognize Physical Status P modifiers." [3]

Oregon Medicaid:

"(6) Reimbursement for qualifying circumstances codes 99100-99140 and modifiers P1-P6 is bundled in the payment for codes 00100-01999. Do not add charges for 99100-99140 and modifiers P1-P6 in charges for 00100 - 01999." [5]

CPT Assistant:

"The physical status modifiers identify levels of complexity of the anesthesia services, and are reported in conjunction with anesthesia services codes when appropriate. Physical status modifiers are represented by the initial letter "P" followed by the appropriate single digit from 1 to 6 (see the following list). These six levels are included in the Anesthesia guidelines of the CPT codebook to distinguish among various levels of complexity of the anesthesia service provided. Other modifiers located in Appendix A of the CPT codebook may also be appropriate. These six levels are consistent with the American Society of Anesthesiologists ranking of patient physical status, which can also be found at the ASA web site www.asahq.org/clinical/physicalstatus.htm." [2]

Cross References

"Modifier 47 - Anesthesia By Surgeon." Moda Health Reimbursement Policy Manual, RPM031.

References & Resources

1. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 2 Anesthesia Services.
2. American Medical Association. "Anesthesia Services Codes 00100-01999 FAQs." *CPT Assistant.* April 2008: 3-4.
3. NHIC, Corp. *Anesthesia Billing Guide.* NHIC, Corp. A CMS Intermediary J14 A/B. April 2013: 18.

4. "Anesthesia Fast Facts." American Society of Anesthesiologists. August 6, 2013. http://www.asahq.org/For-the-Public-and-Media/Press-Room/Anesthesia-Fast-Facts.aspx .

5. OHA. "Anesthesia Services." *Oregon Health Authority.* OHA Health Systems Division: Medical Assistance Programs - Chapter 410, Division 130 Medical-Surgical Services, 410-130-0368 Anesthesia Services. Last accessed March 8, 2019.

   https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=85446 .

6. Noridian. "Anesthesia and Pain Management." November 20, 2018: March 8, 2019. https://med.noridianmedicare.com/web/jeb/specialties/anesthesia-pain-management .

Background Information

Modifiers

Modifiers are two-character suffixes (alpha and/or numeric) that are attached to a procedure code. CPT modifiers are defined by the American Medical Association (AMA). HCPCS Level II modifiers are defined by the Centers for Medicare and Medicaid Services (CMS). Like CPT codes, the use of modifiers requires explicit understanding of the purpose of each modifier.

Modifiers provide a way to indicate that the service or procedure has been altered by some specific circumstance but has not been changed in definition or code. Modifiers are intended to communicate specific information about a certain service or procedure that is not already contained in the code definition itself. Some examples are:

- To differentiate between the surgeon, assistant surgeon, and facility fee claims for the same surgery
- To indicate that a procedure was performed bilaterally
- To report multiple procedures performed at the same session by the same provider
- To report only the professional component or only the technical component of a procedure or service
- To designate the specific part of the body that the procedure is performed on (e.g. T3 = Left foot, fourth digit)
- To indicate special ambulance circumstances

More than one modifier can be attached to a procedure code when applicable. Not all modifiers can be used with all procedure codes.

Modifiers do not ensure reimbursement. Some modifiers increase or decrease reimbursement; others are only informational.

Modifiers are not intended to be used to report services that are "similar" or "closely related" to a procedure code. If there is no code or combination of codes or modifier(s) to accurately report the service that was performed, provide written documentation and use the unlisted code closest to the section which resembles the type of service provided to report the service.

Anesthesia

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." (ASA[4])

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
8/14/2024	Formatting updates. No policy changes.
9/20/2023	Formatting updates. No policy changes.
9/14/2022	Formatting updates. No policy changes.
8/14/2013	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
1/1/2022	Original Effective Date (with or without formal documentation). Policy based on CMS, OHA, & CPT Assistant (AMA) guidelines.