Scope
This policy applies to all Commercial medical plans, Medicare Advantage plans, Summit Health plans, and Oregon Medicaid. Each line of business is addressed separately in the Reimbursement Guidelines.

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. (Noridian®)
   2. For dates of service 6/30/2019 and prior, additional reimbursement is allowed for modifiers P3-P5.
      a. The additional reimbursement is equivalent of additional anesthesia time at the fee schedule rate:
         i. P3 = 15 minutes
         ii. P4 = 30 minutes
         iii. P5 = 45 minutes
   b. Appropriate use of physical status modifiers:
      Appended to CPT codes 00100 through 01999 (anesthesia service/procedure codes).
   c. Improper use of physical status modifiers:
      i. Appended to CPT codes other than 00100 through 01999 (anesthesia service/procedure codes).
      ii.Appending one of these modifiers for a situation other than the one described by the modifier descriptor.
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.” (OHA5)

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:

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

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

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

### Modifier Definitions:

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### Coding Guidelines

**Medicare:**

“Physician status (P1-P6) – not recognized by Medicare.” (Noridian⁶)

“Medicare does not recognize Physical Status P modifiers.” (CMS³)
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.” (OHA5)

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.” (AMA2)

Cross References

References & Resources

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)³

**IMPORTANT STATEMENT**

The purpose of this Reimbursement Policy is to document Moda Health’s 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. Moda Health Reimbursement Policy is not intended to impact care decisions or medical practice.
Providers are responsible for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Providers are expected to submit claims for services rendered using valid codes from HIPAA-approved code sets. 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 the Moda Health 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 Moda Health Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; Moda Health strives 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 *****