Priority Health	BILLING POLICY No. 107
ANESTHESIA SERVICES	
Date of origin: Sept. 2021	**Review dates: 7/2025, 4/2026, 7/2026**

DEFINITION

These guidelines cover general, inhalation, regional, peripheral block, spinal, epidural, IV regional block, field block and local anesthesia services, monitored anesthesia care (MAC), and moderate sedation. If appropriate coding, billing or reimbursement guidelines detailed in policy aren't followed, claims may result in a claim denial or recovery of claim payment.

MEDICAL POLICY

- Moderate Sedation for Interventional Pain Management (#91632)

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the provider. In addition, the provider should consult any specific documentation requirements that are necessary for any applicable defined guidelines.

Billing details

Payable:

- When reported with either base units and time units or with global fees (see below)

Not payable:

- **When the procedure for which anesthesia is administered is non-covered**, anesthesia services will not be payable.
- **Separate payment for the anesthesia service performed by the physician who also furnishes the medical or surgical service**, since the anesthesia service is included in the payment for the medical or surgical service. See the anesthesia modifiers list.
  - Anesthesia services are included in the CPT code for surgical service.
  - Modifier 47 would be appended to the surgical CPT code.
- **Durable medical equipment and any associated supplies** to administer anesthesia when it is needed to perform procedures reimbursed under global fees. (For example: tubing, needles, etc. This is not an all-inclusive list.)

Coding specifics

Preventive services, professional and facility claims

Female sterilization: If sterilization is the only reason for the encounter, report CPT code 00851or 00952 for anesthesia.

Anesthesia services include pre-operative evaluation, administration of anesthetic, medications, blood and fluids, monitoring of the patient and other supportive services:

- The most complex anesthesia service should be billed corresponding to the surgical procedure's anatomical location.
- When the surgical procedure is canceled after the pre-op exam is performed, anesthesia services should not be reported. An evaluation and management service may be reported.

Multiple anesthesia services

Only the most complex anesthesia service should be reported per surgical session. This aligns with ASA billing guidelines. Base units are calculated for the primary procedure and any additional anesthesia procedures will be denied.

If two different providers bill duplicate anesthesia services, only the first submission of that code will be paid.

Exception: Modifiers applied to indicate service performed was medically directed.

- Add-on codes 01953, 01968 or 01969, which are listed separately in addition to the code for the primary procedure
- We don't provide additional reimbursement for unusual positioning even with use of modifier 22.

Postoperative pain management services

- Postoperative pain management services may be reported by anesthesia providers.
- Documentation must support post op pain management
- Diagnosis associated with post op pain management must be linked to claim line. Example: G89.18 Other acute postprocedural pain
- If the surgeon asks the anesthesia provider to manage the patient’s pain after the recovery period is over, the anesthesia provider can bill for this separately using modifier 59 or XU. Pain control done by the surgeon is already included in the surgery’s overall cost, but the surgeon can ask for help from the anesthesia provider if the pain treatment needed is beyond their skill level.

  In specific situations, an anesthesia practitioner can separately report an epidural or peripheral nerve block injection (whether bolus, intermittent bolus, or continuous infusion) for managing postoperative pain, if the surgeon requests help with postoperative pain management."

- An epidural injection (CPT code 623XX) for managing postoperative pain can be billed separately with an anesthesia code (0XXXX) only if general anesthesia is used during the operation and the effectiveness of the anesthesia does not rely on the epidural injection.
- An epidural or peripheral nerve block injection (e.g., 62320-62327 or 64400-64530) given before or during surgery cannot be billed separately for postoperative pain management if the anesthesia used is monitored anesthesia care, moderate conscious sedation, regional anesthesia by peripheral nerve block, or any other type not mentioned.
- An epidural or peripheral nerve block used for intraoperative pain management is covered under the 0XXXX anesthesia code and cannot be billed separately, even if it also manages postoperative pain.
- A peripheral nerve block injection (CPT codes 64XXX) for postoperative pain can be billed separately with an anesthesia code (0XXXX) only if the intraoperative anesthesia is general, subarachnoid, or epidural, and its effectiveness doesn't depend on the nerve block.
- Postoperative pain management shall not be reported with CPT 62320-62327 if a narcotic or analgesic is injected postoperatively through the same catheter as the anesthetic agent.

CRNA billing

Certified Registered Nurse Anesthetists (CRNAs) can personally perform anesthesia services without medical direction.

- QZ modifier must be appended to anesthesia service.

When CRNA oversight is required, these services are reimbursed on a 50% split with the supervising anesthesiologist.

- Appropriate modifier must be appended to report the medical direction/oversight required (Modifier QX).

Physician oversight

Physicians may provide medical directions to CRNA's, Anesthesiologist Assistants or Residents in 2, 3 or 4 concurrent cases

The Anesthesiologist must perform and document the following:

- Pre-anesthesia evaluation
- Establish the anesthesia plan
- Participating in induction and emergence
- Oversee procedures performed are performed by qualified individuals
- Oversee and monitor the course of anesthesia frequently
- Is physically present for immediate emergencies to diagnose and treat
- Provision of post-anesthetic care

Base units and time units

Base unit values have been assigned to anesthesia CPT codes by the American Society of Anesthesiologists (ASA). We determine payment for most anesthesia services by both the CPT code base value and the time the service takes. Time units are measured in 15-minute increments.

Reporting anesthesia time units

You must report units on the claim line item (example: 1/2 hour = report two units). The actual time should also be reported on the claim in box 19. (Example: "Service began at 11:30 a.m. and ended at 1:25 p.m.")

- Reporting begins: When induction is initiated, generally within a few minutes of the initiation of the operative session
- Reporting ends: When the patient is transferred to the recovery room and the provider is no longer in personal attendance

Anesthesia services reimbursed based on global fees

Certain procedures are reimbursed based on a global fee rather than base value and time units, including (but not limited to):

- Usual preoperative and postoperative visits
- Administration of fluids
- Anesthesia care during the procedure
- Local anesthesia during surgery
- Monitoring of electrocardiograms (EKGs), pulse, breathing, blood pressure, electroencephalograms, and other neurological monitoring
- Procedures (example: arterial line insertion)
- Monitoring of left ventricular or valve function via transesophageal echocardiogram
- Monitoring of intravascular fluids (IVs), blood administration and fluids used during cold cardioplegia through non-invasive means
- Maintenance of open airway and ventilatory measurements and monitoring.

Qualifying circumstances

Anesthesia procedure or service provided to identify qualifying circumstances (Separate reimbursement is not made for codes below):

- 99100: Anesthesia for patient of extreme age, younger than 1 year and older than 70; *Reference anesthesia services 00326, 00561, 00834, and 00836 to confirm accurate coding
- 99116: Anesthesia complicated by utilization of the total body hypothermia
- 99135: Anesthesia complicated by utilization of controlled hypotension
- 99140: Anesthesia complicated by emergency conditions

Monitored Anesthesia Care (MAC)

Monitored anesthesia care is eligible for coverage when performed by the anesthesiologist, CRNA or qualified anesthetist under the medical direction of a physician. In alignment with CMS, we would follow CMS outlined criteria for billing, coding, and documentation standards for MAC services.

- Monitored anesthesia claims must be reported with modifier QS on claim
- Monitored anesthesia care is reimbursed only to a single provider per day (anesthetist or anesthesiologist)

Moderate sedation

Moderate sedation billing

Payable	Not Payable
Billed by the same physician or qualified health professional who performs the service requiring sedation	Billed by a separate anesthesiologist.
Billed with modifier 59, XE, XP, XS or XU on the same date of service as local or topical anesthesia performed by the same provider, unless the provider's specialty is Anesthesiology or Certified Registered Nurse Anesthetist (CRNA)	Billed without modifier 59, XE, XP, XS or XU on the same date of service as local or topical anesthesia performed by the same provider, unless the provider's specialty is Anesthesiology or Certified Registered Nurse Anesthetist (CRNA)

Sedation with surgery

When a provider bills the moderate sedation codes in addition to surgical code(s), notes may be requested. Refer to the CPT manual for moderate sedation codes.

Reimbursement specifics

Priority Health Medicare anesthesia billing

Providers under contract for Priority Health branded Medicare products will be paid according to the contract. These providers should bill according to Medicare rules; general Medicare payment rules apply.

Providers not under contract with Priority Health Medicare Advantage products will be paid according to Medicare payment schedules for the geographic area in which the provider practices.

Modifiers

Priority Health follows standard billing and coding guidelines, which include CMS NCCI. Modifiers should be applied when applicable based on this guidance, and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Please see our provider manual page for modifier use here.

Priority Health aligns with CMS and does not recognize or issue additional reimbursement for Physical Status (P) modifiers for Medicare and EH Medicaid plans

The P-modifiers are reported in conjunction with anesthesia CPT® code (00100-01999) when appropriate.

- Physical status modifiers are required for anesthesia services.

Modifier	Description	Reimbursement
AA	Anesthesia services performed personally by the anesthesiologist	100% of allowance
AD	Medical supervision by a physician; more than four concurrent anesthesia procedures	50% of allowance
QK	Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals	50% of allowance
QX	CRNA service; with medical direction by a physician	50% of allowance
QY	Medical direction of one qualified non-physician anesthetist by an anesthesiologist	50% of allowance
QZ	CRNA service; without medical direction by a physician	100% of allowance

Place of service
Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information in our Provider Manual.

Reimbursement rates
Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. See our fee schedules (login required).

REFERENCES

- Medicare NCCI 2025 Coding Policy Manual – Chapter 2 (CMS)

DISCLAIMER
CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies, and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis, and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS), and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry-standard, compliant codes defined by CPT, HCPCS, and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste, and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made

July 11, 2025	• Added "Priority Health Medicare anesthesia billing" section
	• Added the following to the "Post operative pain management services" section:
	  ○ Modifier 59 and XU use information
	  ○ Epidural and peripheral nerve block billing requirements
	  ○ Guidelines for reporting postoperative pain management when administered through the same catheter as the anesthetic agent

April 21, 2026	• Added table under Moderate sedation billing section
July 8, 2026	• Reviewed- No updates needed