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Evaluating Anesthesia Billing and RCM Vendors: The Complete Guide

By Joe Laden Vice President Client Management

What's inside

All medical specialties have unique rules and nuances when it comes to billing and revenue cycle management. However, anesthesia billing stands apart due to its highly specialized charge formulas, time-based units, modifiers, code mapping, and the overall level of precision required to ensure full reimbursement.

Given the complexity and uniqueness of anesthesia billing, it's no wonder that many anesthesia practices look to billing experts. The challenge for anesthesia groups is that while many billing and coding companies claim expertise, their proposals and bids often leave out key requirements. The result? Missed opportunities for collecting every dollar earned.

When evaluating an anesthesia billing and revenue cycle management (RCM) partner, it's easy to overlook critical technical details in the rush to make a decision. That's why it's essential to use a comprehensive checklist to guide your selection. By reviewing all the key requirements of anesthesia billing at once, you can ensure your chosen partner has the expertise and capabilities needed across every necessary area.

While technical expertise is a necessity, equally important is to find a billing company that shares your values and culture – one that's large enough to scale with your practice but still delivers white-glove customer service.

The following checklist can be used to guide your decision-making when evaluating whether a potential billing partner meets the full spectrum of anesthesia-specific requirements to best fit the needs of your practice.

Embrace complexity: anesthesia RCM fundamentals

The unique billing methodology of anesthesia

Anesthesia has a separate set of CPT codes that are different from specialty CPT codes. Anesthesia time-based administration is billed under the type of service code 7. Each anesthesia CPT code has an associated number of base units, and these base units are combined with time units to produce the amount billed for anesthesia. Time units are usually one unit per 15 minutes of anesthesia administration time, but some payers allow 10-minute units or 12-minute units. Anesthesia RCM and billing plays by its own rules. When seeking an anesthesia billing partner, make sure they speak the language fluently and know the system inside and out.

American Society of Anesthesiologists (ASA) physical status classification system

The ASA Physical Status Classification System is used to assess and categorize a patient's overall health prior to the administration of anesthesia. This classification not only reflects clinical complexity but also directly impacts reimbursement. Specifically, when a patient is classified as ASA Physical Status P3 through P5, additional anesthesia units can be billed – but only when the appropriate physical status codes are added to the modifier field on the claim form. Because reimbursements are tied to accurate ASA coding and proper claim submission, it's important to work with a billing partner who understands how to capture and apply ASA physical status codes to maximize revenue.

Anesthesia qualifying circumstance modifiers

Anesthesia's unique add-on qualifying circumstance modifiers include multiple codes – 99100, 99116, 99135 and 99140. It's important to note that not all payers pay for all codes. In fact, some payers require that certain codes not be billed at all. For example, the "extremities of age" code may not be billed to Medicare. When choosing a billing company, it is important to make sure they understand the nuances of qualifying circumstance modifiers, including when they can and cannot be used.

Modifier	Use Case ✔	Restrictions ✕
99100	Pediatric, geriatric	Not reimbursed by Medicare
99116	Hypothermia	Some payers deny automatically
99135	Controlled hypotension	Often requires documentation
99140	Emergency anesthesia	Emergency must be documented

Non-anesthesia procedures billed with anesthesia

In addition to billing for time-based anesthesia services, providers may also bill for the placement of post-operative pain control blocks or the insertion of arterial and central lines during a case. These additional procedures must comply with correct coding initiative (CCI) edits and require appropriate use of modifier codes. If you want to collect every dollar you've earned, your billing team must be well-versed in the ins and outs of this process.

Monitored anesthesia care

Most methods of anesthesia, including general, regional, spinal, and TIVA, are paid the same. However, monitored anesthesia care (MAC) is submitted with the QS modifier and is treated differently by payers. Some payers reject this type of anesthesia if it is not submitted with certain qualifying diagnosis codes, while others handle the deductible differently for monitored anesthesia care depending on the anesthesia CPT code submitted. Because of these variations, you should look for a billing partner who has a deep understanding of MAC billing rules to ensure full claim reimbursement.

Rounding of time units

Anesthesia claims are submitted based on the time duration of anesthesia in minutes, which payers then convert into time units for reimbursement. However, the method of conversion varies as some payers round up to the next whole unit, while others calculate to the nearest tenth. These subtle differences in payer policies can significantly impact reimbursement. Optimizing billing starts with precision. That's why it's important to partner with a team that not only grasps the subtleties of anesthesia time units but knows how to act on them.

Timekeeping

In addition to tracking the total time duration of an anesthesia case, anesthesia billing also occurs on a time-based system, in which time must be tracked for every provider who works on a case. It is not uncommon to have two anesthesiologists and three CRNAs or CAAs providing services on a single case. Each provider's time must be tracked to the minute. It's important to find an anesthesia billing partner who has a process to track and apply time-based systems for full reimbursement.

Did you know?

When more than one provider is involved on a case, their exact start and stop times must be tracked **separately** to properly assign modifiers like QK, QX, QY, and QZ. This level of time granularity directly determines reimbursement and compliance status.

Crack the code: anesthesia compliance challenges

Coding complexities

Since anesthesia has a separate set of CPT codes from other specialties, the first anesthesia coding step is to determine the code for the surgical procedure and then use a crosswalk system to map the surgical CPT code to an anesthesia CPT code. Mapping is not necessarily one-to-one and requires an experienced anesthesia coding partner to do it properly.

Anesthesia rules for medical direction and supervision

Medicare has separate sections in the payer payment manual for anesthesia (see chapter 12 Sections 50 and 140.3). In these sections, Medicare details the billing rules for cases that are attended by a combination of anesthesiologists, CRNAs, CAAs, and anesthesiology residents.

Anesthesia cases are billed and reimbursed differently depending on the combination of providers on each case – and what their roles are. There are six modifiers used for this purpose and four other modifiers unique to anesthesia.

> "Health Prime's team is exceptional. Their expertise has improved our coding, reduced AR days, and strengthened collections—making our revenue cycle more efficient."
>
> **— Seven Hills Anesthesia**

When multiple providers are involved in an anesthesia case, a process called concurrency checking is used to ensure there are no time conflicts between providers. This system tracks, minute by minute, the number of CRNAs or CAAs being medically directed or supervised to determine the maximum concurrency level during the case. The specific way an anesthesia service is delivered impacts how payments are delivered, which is another reason why you need to ensure you choose a billing company who has knowledge and experience in this intricate process.

Auditing

Due to the unique complexities of anesthesia RCM, both internal and external audits require specialized auditors with experience in anesthesia-specific guidelines. Effective auditing involves reviewing medical direction and modifier usage for compliance, as well as verifying the accuracy of CPT and diagnosis coding to ensure proper reimbursement and reduce the risk of denials. This level of expertise is crucial because even small errors can lead to significant revenue loss, compliance violations, or payer audits. A knowledgeable auditor helps protect your practice's financial health and ensures you meet regulatory requirements.

Did you know?

Anesthesia auditing is time-sensitive and presence-dependent. An effective audit needs to check that medical direction modifiers are correctly applied based on concurrency level and confirm that required steps for medical direction were completed and documented.

Chronic pain clinic

In addition to operating room anesthesia, many anesthesia practices operate a chronic pain clinic. Coding and billing for chronic pain are similar to medical/surgical billing. Since specialized, non-anesthesia coders may be needed for the pain clinic, it's important to partner with a billing organization with thorough billing and RCM knowledge across a variety of specialties.

Tackle potential pitfalls: payer and contract dynamics

Provider and payer enrollment issues

Many anesthesia practices rely on locum tenens and occasional providers to maintain adequate coverage. However, these provider arrangements often have high turnover rates, leading to significant credentialing challenges.

Ensuring that each provider is properly enrolled with all necessary payers before they begin working is critical for reimbursement. For this reason, a billing partner must have a streamlined and proactive approach to credentialing and payer enrollment to support these dynamic staffing models.

Fee checking for payer contract compliance

As each payer has their own set of rules for calculating and reimbursing anesthesia services, it's important to conduct a payment analysis on all paid claims. This analysis should include checking payments from both government and commercial payers, as well as checking each claim line against the specific billing and reimbursement rules of the corresponding payer.

This process helps enforce the contract and ensures anesthesia groups get full reimbursement at the contracted rate. When seeking vendor partnership, look for one who proactively advocates for your practice, challenges underpayments, and protects your revenue from slipping through the cracks.

Anesthesia practices face declining reimbursement

In 2025, the Medicare Physician Fee Schedule included a reduction in the conversion factor, which **reduced anesthesia payments by 2.2%.**

A 2023 report showed Medicare reimbursements for anesthesia services **dropped from $22.27 per unit in 2019 to $21.12 in 2023.**

Several national insurers have announced plans to **cap CRNA reimbursement rates at 85%** of the physician fee schedule.

Estimates

There are occasions where patients may call in advance of surgery for an estimate of their anesthesia bill. However, because this type of billing is time-based and the exact length of surgery is unknown, an accurate estimate may be difficult to calculate.

It's important to choose a billing vendor with the ability to provide good faith estimates to patients as these can help a patient prepay cosmetic or other surgical anesthesia not covered by insurance.

Obstetrical anesthesia billing

Unlike operative anesthesia services, there is no single, widely accepted time tracking method for neuraxial labor anesthesia services. Each government and commercial payer can have its own requirements for billing these services, usually based on the duration of the service or contact time with the patient.

Methods of payment vary and can be billed at a flat rate or based on time with maximum time limitations. Because of the duration of a labor epidural, which can be as much as 24 hours, most anesthesia practices set a cap on the billing charges to a reasonable maximum amount to avoid a large "surprise" bill to the patient. It's essential to work with a billing partner who understands the unique complexities of obstetrical anesthesia and can strike the right balance between compliance, accuracy, and patient transparency.

Leverage technology: data and reporting

Data acquisition

Anesthesia practices rely on the electronic medical records (EMRs) used by the facilities where they provide care. As a result, anesthesiology groups must establish EMR and demographic interfaces at each facility. Since most anesthesiologists operate across multiple locations, it's essential to choose a billing partner who understands the unique documentation workflows at each site. This knowledge is critical to ensure accurate data capture, streamlined billing processes, and the prevention of revenue leakage.

Reporting and data mining

Because anesthesia billing is mostly time-based and multiple providers can be billed for different segments of a case – either individually or simultaneously – many varying elements must be stored, and reported, for each case. Highly detailed reporting is necessary, including with and without time factors, base units and time units. Additionally, each reported case will have an anesthesia CPT code and a surgical CPT code. There is also a different set of reporting elements needed for pain clinics.

This detailed level of reporting, and the many nuances involved, highlights why it is imperative for anesthesia practices to choose a billing partner with a robust reporting and data management system in place. The right billing partner turns data into insight – delivering time-based production reports that break down anesthesia utilization by the facility, operating room, and provider with precision.

Final thoughts on anesthesia RCM partnerships:

Selecting the right anesthesia billing partner requires more than a general understanding of medical billing – it demands deep, proven expertise in the distinct processes that define anesthesia revenue cycle management. From time-based charge calculations and modifier use to payer-specific nuances and compliance requirements, the stakes are simply too high for assumptions or shortcuts.

This checklist is designed to be used as a guide to provide a structured, comprehensive view of what truly matters when evaluating an anesthesia RCM partner. By approaching the decision with clarity and thoroughness, you'll be better positioned to choose a partner who can deliver technical expertise, world-class customer service, measurable operational and financial improvements, and a streamlined patient experience.

To learn why Health Prime is a trusted partner to more than 800 clients nationwide, visit hpiinc.com/anesthesia.

Joe Laden is the Vice President of Client Management at Health Prime, as well as a nationally recognized anesthesia speaker.

Health Prime is a leading provider of customized revenue cycle management solutions for anesthesia groups, accelerating reimbursement for thousands of physicians nationwide. Backed by a global team of 5,000 employees across the U.S., Latin America, and Asia, we drive long-term success through unwavering support, so you can focus on what matters most: your patients.