



# Optimize Your Anesthesia Billing: Strategies to Reduce Claim Denials



Minimizing anesthesia billing denials is essential as they can lead to delayed or lost revenue. With the right processes—and a clear understanding of how rejections and denials differ—billers can avoid or resolve issues that impact reimbursement.

**Rejection:** A claim that’s incomplete or invalid—typically due to missing information or coding errors—before it’s processed by the payer.

**Denial:** A processed claim the payer refuses to reimburse, often due to lack of coverage, medical necessity, missing preauthorization, etc.

The following best practices can help proactively reduce anesthesia claim denials and improve your financial health.

## Understanding anesthesia billing fundamentals can lead to fewer claim denials

What makes billing for anesthesia services more complex than other specialties is its unique payment system, which requires careful attention to detail to prevent denials. This system includes:

- **Base units:** Each anesthesia procedure code is assigned a corresponding base unit



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value by Centers for Medicare & Medicaid Services (CMS). The more complex the procedure, the higher the base unit, directly impacting the potential for reimbursement.

- **Time units:** These represent the duration an anesthesia practitioner is present with a patient. It is computed by dividing the reported anesthesia time by 15 minutes. Accurate time tracking is critical to avoid anesthesia claim denials.
- **Modifying units:** These account for special conditions or emergencies that may affect the anesthesia service, influencing



the total billable amount and requiring precise application to prevent denials.

- **Conversion factor:** This number is determined for each locality where services are performed, serving as a multiplier in the reimbursement calculation.

The formula for reimbursement for anesthesiologists or certified registered nurse anesthetist (CRNA) follows:

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$$\text{( Base Factor + Total Time Units )} \times \text{Anesthesia Conversion Factor} \times \text{Modifier Adjustment}$$

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For anesthesia performed under medical direction:

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$$\text{[ ( Base Factor + Total Time Units )} \times \text{Anesthesia Conversion Factor ]} \times \text{Modifier Adjustment}$$

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These fundamentals highlight how anesthesia billing is not your run-of-the-mill medical billing. You can significantly reduce denied claims by having a basic understanding of how anesthesia care is provided and knowing the best practices in anesthesia medical billing.

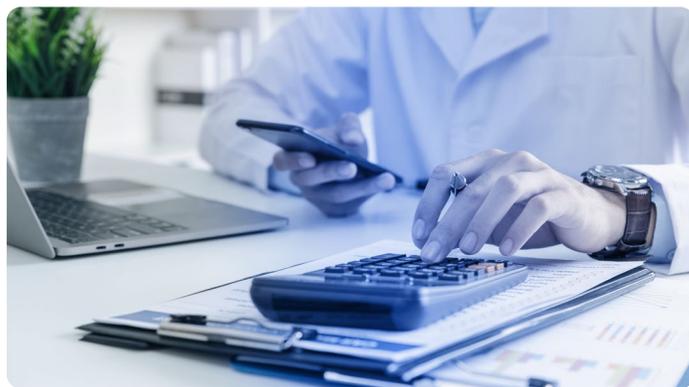
## Adhering to anesthesia coding guidelines

Different types of anesthesia have unique billing codes, which can be confusing for billers who lack a deep understanding of anesthesia services. Knowledge, coupled with clear and accurate documentation of codes and modifiers, can help avoid common errors that lead to anesthesia claim denials.

## Using anesthesia modifiers to avoid claim denials

Modifiers must be added to procedure codes when billing. These are two-character indicators that signify relevant details, like age, physical status and emergency factors on a claim. When billers are unaware of proper modifier usage, the result can be inappropriate billing and, consequently, denied claims. Correct modifiers and codes ensure consistency and accuracy in reimbursements while remaining compliant. They also prevent issues like unbundling and duplicate billing.

The Healthcare Common Procedure Coding System (HCPCS) indicates modifiers specific to anesthesia services are standard on claims submitted to Medicare and many other payers. Adherence to these guidelines is crucial for optimizing your anesthesia billing.



## Effective strategies for denied anesthesia billing claims

When claims are denied, a structured approach is essential. The biller performs a root-cause analysis to identify issues that need correction. Once the reason for the anesthesia claim denial has been identified, the biller proceeds with the following actions:

### Steps to appeal anesthesia claim denials

- **Gather the required appeal documentation.** This typically includes a letter of appeal that explains why you are appealing and how your documentation supports those

reasons. Supporting documentation may also include patient lab reports and progress notes. You will need a claim number or an explanation of benefits (EOB) to avoid duplication and track your claim efficiently.

- **Follow the insurer's specific appeals process.** Each insurance company has a unique way of accepting appeals. Billers must ensure they are aware of these specific requirements to optimize the appeal process.
- **Send the appeal to the payer.** Billers know where to send claims, typically from the mail or the company's website, after receiving the insurance-specific forms. The address may also be seen on the EOB.

## Follow-up strategies to minimize anesthesia claim denials

Following up on denied claims helps you run your practice or group smoothly and successfully as you ensure every owed amount is received as quickly as possible.

**Proactive follow-up is the cornerstone of effective anesthesia billing denial management.**

### Using anesthesia modifiers to avoid claim denials

When following up, ask these questions and meticulously record the responses:

- **When was the claim received?** Follow-up with the insurer within 30 days to verify if the claim was received and/or is in process.
- **Has the claim been assigned a number?** Make a note of the number provided for easy reference.

- **Are additional documents needed to complete the claim processing?**

Follow up in seven to 10 days to ensure the claim is in process.

- **What is the target completion date for the claim processing?** Make a note of the date and expect payment accordingly.
- **What is the reference number?** Keep track of this information, as it allows you to document all calls and names of contacts going forward, which is vital for resolving anesthesia claim denials.

These detailed strategies are the foundation—but true impact often comes from seeing the bigger picture.

## Optimizing anesthesia billing through better processes

If your practice or group is struggling with delayed or denied claims, one of the most effective levers to pull is A/R follow-up. A dedicated follow-up process doesn't just keep your revenue cycle moving—it gives your team visibility into which issues are costing you most.



Whether it's denial management, coding gaps or overlooked authorization steps, analyzing patterns in denied claims helps you improve future outcomes. Medical billing trends change constantly, and staying ahead

of them is critical to improving your first-pass rate and reducing the burden of rework.

Tools like denial management software can bring structure and consistency to the process, but it's often the workflows themselves—appeals, coding review, documentation and follow-up—that make the biggest difference.

**When aligned well, these practices support a stronger, more resilient anesthesia billing process.**

Ultimately, the most reliable collections outcomes come from consistent attention to detail and a willingness to improve what's already in place. Benchmarking your current approach against anesthesia billing best practices is a smart way to uncover new opportunities and reduce future denials.

Want to explore what's working in the field? Take a deeper look at how others are evolving their anesthesia billing solutions and A/R follow-up strategies to build healthier revenue cycles. anesthesia billing services can reduce claim denials and strengthen your revenue cycle.



**When workflows work together, revenue flows stronger.**



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