

## Anesthesia Payment Policy

**Line of Business: McLaren Health Plan Medicaid, McLaren Health Advantage, McLaren Community, McLaren Medicare Advantage**

**Effective Date: 9/1/2026**

This policy applies to anesthesia services. If there is a conflict between this policy and applicable federal or state laws, regulations or regulatory requirements, the applicable laws or regulations will control. Further, if there is a conflict between this policy and a provider contract, the provider contract will govern. Note – coverage may be mandated by MDHHS or CMS.

Providers are required to submit accurate claims and documentation for all services performed.

Providers must submit claims using valid code combinations required by applicable law. Claims should be coded appropriately according to industry standard coding guidelines. All claims are subject to claim edits and may be subject to further reviews by McLaren or contracted third parties. Providers are expected to promptly work with McLaren and any third parties to provide any requested information related to claim submission.

### Modifier Reimbursement Policy:

McLaren reimburses anesthesia services as follows:

Modifier	Description	Medicaid Payment % of Allowable	All other LOB Payment % of Allowable
AA	Physician personally directs the entire case	100%	100%
AD	Physician supervising more than four concurrent cases	60%	50%
GC	Physician supervising up to two anesthesia residents	100%	100%
QK	Physician directing two, three or four concurrent cases involving CRNAs or anesthesia assistants	60%	50%
QY	Physician is medical directing one CRNA	60%	50%
QX	CRNAs and anesthesia assistants, when medically directed by an anesthesiologist	40%	50%
QZ	Services performed by CRNAs without the medical direction of an anesthesiologist	100%	100%

**Multiple Anesthesia Providers:**

If two different providers bill duplicate anesthesia services, only the first submission of the code will be paid. The only exception would be if the billing reflected services performed with medical direction.

When services billed are reported with a modifier noting “without medical direction” and another anesthesia service is billed for the same date of service noting “with medical direction” this is a coding conflict. This will result in claims denials. Review for appropriate modifier reporting prior to billing.

**Unit Reporting**

The American Society of Anesthesiologist (ASA) has assigned base units to anesthesia CPT codes. McLaren calculates the payment using the CPT code base units and the duration of services. Time units are measured in 15-minute increments (example: 1 hour = report 4 units). Do not report the base units as this is automatically added based on the ASA assignment.

Medicaid claims are reimbursed off the MDHHS established rate. Commercial and Health Advantage claims are reimbursed off contracted rates specific to each Provider. Medicare claims are reimbursed off CMS rates unless otherwise contracted Provider.

**Audit**

McLaren or a third party may audit or otherwise review all paid claims to ensure the integrity of the paid claims. This includes, but is not limited to coding validation, payment accuracy, compliance with regulations, policies, and contractual requirements. These reviews include clinical claim reviews and payment analytics.

**Sources:**

*MDHHS Provider Manual*

<https://www.michigan.gov/mdhhs/doing-business/providers/providers/medicaid/policyforms/medicaid-provider-manual>

MDHHS Provider Manual Pages 21-22 and Page 42 of the Billing & Reimbursement for Professionals Section.

*CMS Resources*

Medicare Claims Processing Manual Chapter 12

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104C12.pdf>

Section 50 Payment for Anesthesiology Services and Section 140.3.3 Billing Modifiers