Coding for Anesthesia Services

I. INTRODUCTION

AAOMS members frequently inquire about the proper coding of anesthesia services performed by the OMS. Definitions for levels of sedation and anesthesia may be found in the *AAOMS Parameters of Care*, the American Dental Association's (ADA) Current Dental Terminology (CDT) Manual and the AMA Current Procedural Terminology (CPT). Levels of anesthesia and sedation also may be defined in individual state board regulations.

This paper provides general coding guidance because significant variations in licensing, credentialing and coverage may exist by region, state and/or individual carriers. Thus, there is no single rule that uniformly governs this service. Ultimately, how anesthesia services provided by the surgeon are reported depends on the individual insurance carrier and/or plan.

Note: Under both medical (CPT) and dental (CDT) coding, the use of local anesthesia is generally considered an inherent component of a surgical service or procedure; therefore, it is not reported or billed separately.

II. DEFINING START AND STOP TIME

Understanding CPT and CDT definitions of anesthesia start and stop times is a very important aspect of coding and billing for anesthesia services. It also is important to note that only the provider's time may be considered as billable time. The clinical staff time spent prepping the patient for surgery or monitoring the patient in recovery is not billable time.

CPT

Under CPT's guidelines, sedation and anesthesia services are broken down by physician work and/or time into three components: pre-service work, intra-service work and post-service work:

- Pre-service work includes, but is not limited to, things such as assessing the patient and reviewing any pre-sedation diagnostic tests. This also includes checking vital signs, respiratory rate, blood pressure and connecting to an EKG.
- Intra-service work is the provider's time spent furnishing the service and requires the provider's continual face-to-face attendance.

  Note: According to CPT guidelines, intra-service time is used as the basis for defining anesthesia start and stop times for all sedation and anesthesia services under CPT. Thus, this is considered billable time.
- Post-service work may include clinical documentation of the anesthesia services, communicating with family/caregiver and evaluating the patient's readiness for discharge.

According to CPT, anesthesia intra-service time starts when the physician or other qualified health care professional begins to prepare the patient for the induction of anesthesia, in the operating room or equivalent area, and ends when the physician other qualified health care professional providing the sedation ends personal continuous face-to-face time with the patient. In other words, when the patient can safely be placed under postoperative supervision of another person. This means anesthesia services and time are considered completed when the patient may be safely left under the observation of a trained and licensed health care professional who is qualified to monitor post-anesthesia recovery.

Intra-service time includes ordering and/or administrating the initial and subsequent doses of sedating agents and requires continuous face-to-face attendance of the provider administering the sedation and monitoring of the patient's response to the sedating agent. Pre- and post-service work are considered inherent to the sedation or anesthesia service, therefore time spent on these activities may not be used in code selection.

Note: The above guidelines are outlined under the Moderate (Conscious) Sedation section, found in the Medicine chapter of the CPT code book. However, from

a coding standpoint the guidelines and definitions for pre-, intra- and post-service work are also applicable for reporting deep sedation/general anesthesia services under CPT. Refer to the Moderate (Conscious) Sedation guidelines for a complete list of activities that may be included in the pre-, intra- and post-service time/physician work for sedation and anesthesia services.

CDT

Under CDT, anesthesia intra-service time or anesthesia start and stop times, are similarly defined. According to CDT, "anesthesia time begins when the doctor administering the anesthetic agent initiates the appropriate anesthesia and non-invasive monitoring protocol and remains in continuous attendance of the patient. Anesthesia services are considered completed when the patient may be safely left under observation of trained personnel and the doctor may safely leave the room."

Note: CDT's definition of intra-service time is included in the code descriptors for moderate, deep sedation and general anesthesia.

Regardless of the code set being used to report anesthesia services, anesthesia time between surgical cases should not overlap when documented and reported correctly.

III. CODING FOR SEDATION AND ANESTHESIA SERVICES USING CPT CODES

Moderate (Conscious) Sedation

The American Society of Anesthesiologists (ASA) and CPT guidelines define Moderate Sedation/Analgesia as a *drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.*

As noted in section II of this paper, CPT guidelines state intra-service time is used to determine the appropriate CPT code to report moderate (conscious) sedation services. Intra-service time begins with the administration of the sedating agent(s) and ends when the physician or other qualified health care professional can safely leave the patient under postoperative supervision.

Moderate sedation codes under CPT are differentiated by the provider administering the sedation, specifically whether it is the provider who also performs the surgical procedure or a separate practitioner. Moderate sedation codes should not be used to report minimal sedation (anxiolysis), deep sedation or monitored anesthesia care.

Note: According to the May 2025 CPT Assistant, there is no specific code to report minimal sedation, as it is considered a component of the provided procedure/service. Within the CPT code set, sedation services are primarily categorized under moderate (conscious) sedation, deep sedation and general anesthesia, each with specific reporting codes. However, minimal sedation, which involves a drug-induced state in which the patient remains responsive and maintains normal cardiorespiratory function, is considered a component of the primary procedure rather than a distinct, reportable service. In contrast, when moderate sedation is provided, there are specific codes (e.g., 99151-99153, 99155-99157) available to report those services when appropriately documented and when they are separate from the procedural work.

The range of CPT codes used to report moderate sedation services is 99151-99157:

99151 Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient's level of consciousness and physiological status; initial 15 minutes of intraservice time, patient younger than 5 years of age

99152 initial 15 minutes of intraservice time, patient age 5 years or older

99153 each additional 15 minutes intraservice time (List separately in addition to code for primary service)

Note: This is an add-on code and must be used in conjunction with 99151, 99152. Do not report this code in conjunction with 99155, 99156.

99155 Moderate sedation services provided by a physician or qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports; initial 15 minutes of intraservice time, patient younger than 5 years of age

99156 initial 15 minutes of intraservice time, patient age 5 years or older

99157 each additional 15 minutes intraservice time (List separately in addition to code for primary service)

Note: CPT codes 99152, 99153, 99156 and 99157 are add-on codes and must be reported in conjunction with the appropriate primary code – 99151 or 99155.

Deep Sedation / General Anesthesia

The ASA defines deep sedation and general anesthesia as follows:

Deep Sedation *is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.*

General Anesthesia *is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.*

Codes from the anesthesia chapter of the CPT manual, including anesthesia codes for procedures of the head and neck (00100-00352), generally reflect anesthesia services administered by an individual other than the operating surgeon, such as an anesthesiologist or certified registered nurse anesthetist (CRNA). When a code from the anesthesia chapter is reported on a claim, the insurance carrier assumes a separate provider is administering the anesthesia and therefore may request a modifier, such as – AA (Anesthesia services personally performed by the anesthesiologist) or – QZ (Certified Registered Nurse Anesthetist (CRNA) service without medical direction by a physician). These provider type modifiers are not applicable to an OMS who is both administering the anesthesia and rendering the surgical service.

CPT guidelines indicate deep sedation/general anesthesia administered by the operating surgeon – including an OMS – should be reported by appending modifier 47 (Anesthesia by Surgeon) to the surgical procedure code, using a two-line method.

For example, the closed reduction of a mandibular fracture performed in the office under deep sedation / general anesthesia administered by the operating surgeon would be reported as follows:

21451 Closed treatment of mandibular fracture; with manipulation *(fee for surgical procedure)*

21451-47 Anesthesia performed by operating surgeon *(fee for anesthesia services)*

Some insurance companies will permit surgeons to report their anesthesia services by utilizing codes from the anesthesia chapter of the CPT manual, although this is becoming less common. When applicable, such anesthesia services are reported by using the appropriate five-digit code found in the anesthesia chapter of the CPT manual. Some of the most common CPT codes utilized for oral and maxillofacial surgery procedures include 00170 (Anesthesia for intraoral procedures, including biopsy; not otherwise specified) and 00190 (Anesthesia for procedures on facial bones or skull; not otherwise specified).

Coding tip: When reporting CPT anesthesia codes, an OMS also may be able to bill for supply of the anesthetic agent as well as possibly for antibiotic IV therapy, analgesics (pain) and anti-inflammatory (swelling) medications by reporting CPT supply code 99070. Some insurance companies may prefer the appropriate HCPCS Level II code(s) for the specific drug(s) administered (J codes).

It is important to keep in mind coding guidelines and requirements for operator-administered anesthesia can vary by payer. The CPT anesthesia codes are intended to be reported by separate anesthesia providers and, in general, are not used to report anesthesia administered by the operating surgeon. As stated earlier, however, a payer may allow an OMS to report these codes. If a payer does not accept the use of modifier 47 or CPT anesthesia codes, a coder may consider reporting the CDT codes for deep sedation/general anesthesia on the medical claim. To avoid unnecessary claim denials, it is best practice to confirm any reporting or coding requirements with each insurance carrier prior to claim submission.

Reporting Sedation/Anesthesia Time: Minutes versus Units

The medical claim form, or CMS 1500 form, and its electronic equivalent require anesthesia services to be reported as *minutes*. According to the CMS 1500 claim form instruction manual, unless a time period is indicated in the code nomenclature or description, the "units" box (24G) must reflect the total number of anesthesia minutes administered. For instance, if reporting moderate sedation CPT codes (i.e., 99151, 99152) or deep sedation/general anesthesia CDT codes (i.e., D9222, D9223), **the total number of units** would be reported on the medical claim form. However, if reporting codes from the CPT Anesthesia section (00170, 00190), the **total number of minutes** (i.e., 60 mins) would be entered in box 24G of the medical claim form.

In addition, when reporting anesthesia services using the two-line method and appending modifier 47, the **total number of minutes** would be reported in box 24G of the medical claim form. The official instructions for completing the CMS 1500 claim form are maintained by the National Uniform Claim Committee (NUCC) and available at NUCC.org.

Generally, anesthesia time is reported in minutes according to current standards. However, certain payers may still require the reporting of anesthesia time in units.Therefore, it is best to confirm each payer's preferred method of reporting time.

Anesthesia and Medicare

Medicare policy does not allow separate reimbursement for deep sedation/general anesthesia when administered by the operating surgeon. Specifically, Chapter 2 of the National Correct Coding Initiative (NCCI) Policy Manual states "with limited exceptions, Medicare Anesthesia Rules prevent separate payment for anesthesia for a medical or surgical procedure when provided by the physician performing the procedure." In other words, deep sedation/general anesthesia is bundled with the payment for Medicare-covered procedures when both the surgery and anesthesia services are furnished by the same provider. Therefore, an OMS may not charge Medicare or a Medicare beneficiary for deep sedation/general anesthesia services when performed in conjunction with a Medicare-covered service. Medicare may however consider payment for anesthesia services when administered by a separate anesthesia provider. Many third-party payers follow Medicare policy guidelines; therefore, it is possible that other insurance carriers also may bundle payment and not reimburse separately for general anesthesia when administered by the operating surgeon.

Conversely, Medicare may allow separate reimbursement for moderate conscious sedation. According to the NCCI Policy Manual,"Medicare generally allows separate reporting for moderate conscious sedation services (CPT codes 99151-99153) when provided by the same physician performing a medical or surgical procedure except when the anesthesia service is bundled into the procedure." Adherence to this policy varies by state Medicare Administrative Contractor however most will cover moderate sedation when performed by the surgeon. However, it is important to note that coding should be determined based on the highest or deepest level of anesthesia achieved, rather than on the coverage or reimbursement policies of the insurance carrier. The Medicare NCCI Policy Manual is available at CMS.gov/medicare/coding-billing/national-correct-coding-initiative-ncci-edits/medicare-ncci-policy-manual.

IV. CODING FOR SEDATION AND ANESTHESIA USING CDT CODES

There are unique differences between anesthesia billing between CPT and CDT. CDT does not distinguish between operator-administered anesthesia and anesthesia administered by another practitioner. CDT and CPT also have differing guidelines for determining and reporting additional increments of time. Per CDT guidelines, time-based anesthesia codes are reported in defined

time increments. For the code described as "15-minute increment, or any portion thereof," any fraction of a 15-minute period beyond the initial time is considered a reportable unit. Therefore, once the subsequent time increment is initiated, the corresponding CDT code is appropriately billed even if the full 15 minutes are not completed, provided anesthesia services are continuously rendered and documented.

On the other hand, CPT guidelines state that more than half of the increment time must be met in order to report an additional 15 minutes. Lastly, the concepts of facility, supplies and materials also are inherently different in dental and medical billing. It is important to keep each of these differences in mind when coding for anesthesia services.

CDT Evaluation

If an evaluation results in the decision to perform surgery, the anesthesia evaluation is considered part of that same evaluation. CDT code D9219 may be reported on the date of surgery only if the therapeutic evaluation occurred at a prior visit, since an anesthetic evaluation is required before surgery. D9219 should not be reported on the same date of service as another Evaluation and Management code.

D9219 evaluation for moderate sedation, deep sedation or general anesthesia

Enteral vs. Parenteral

To support accurate code selection, it is helpful to understand the distinction between enteral and parenteral routes of administration:

- Enteral refers to drug administration through the gastrointestinal tract, typically by mouth (oral).
- Parenteral involves routes outside the GI tract, such as intramuscular, subcutaneous, intranasal or intrabony delivery.

This distinction is important when selecting among the new and revised codes, as several are route specific.

2026 Anesthesia Coding Changes

The 2025 Code Maintenance Committee (CMC) approved updates to the anesthesia code family for inclusion in the 2026 CDT code set, effective Jan. 1. These updates include revisions related to nitrous oxide, moderate sedation and deep sedation/general anesthesia.

Note: Only code nomenclature is provided in this paper. To ensure accurate reporting, it is essential to review the complete code nomenclature and descriptors when selecting the appropriate code. Final code selection should be based on whether the reported service fully meets the requirements outlined in the code description.

Deleted code

D9248 D9248 non-intravenous conscious sedation

Revised codes

D9230 administration of nitrous oxide

Coding tip: CDT code D9230 applies exclusively to the administration of nitrous oxide as the sole agent.

D9239 administration of moderate sedation – intravenous – first 15 minutes increment, or any portion thereof

Coding tip: CDT code D9239 is reported for the first 15 minutes of moderate sedation achieved by administering and adjusting the dosage of drugs intravenously. Nitrous oxide may be used in conjunction with other IV drugs to enhance the sedation effect, but it is not necessary for achieving moderate sedation.

D9243 administration of moderate sedation – intravenous – each subsequent 15 minute increment, or any portion thereof

Coding tip: CDT code D9243 is used to code each subsequent 15-minute increment of moderate sedation achieved by administering and adjusting the dosage of drugs intravenously.

D9222 administration of deep sedation/general anesthesia – first 15 minutes increment, or any portion thereof

Coding tip: CDT code D9222 is reported for the first 15 minutes of deep sedation/general anesthesia achieved by gradually adjusting the drug dosage until the desired level of anesthesia is achieved. Nitrous oxide may

be used in conjunction with other IV drugs to enhance sedation, but it is not required to achieve deep sedation/general anesthesia. When general anesthesia involves an advanced airway, report new codes D9224/D9225. When general anesthesia is administered with an oral pharyngeal airway and nasal pharyngeal airway, report D9222/D9223.

D9223 administration of deep sedation/general anesthesia – each subsequent 15 minute increment, or any portion thereof

Coding tip: CDT code D9223 is used to code each subsequent 15-minute increment of deep sedation/ general anesthesia achieved by gradually adjusting the drug dosage until the desired level of sedation is reached.

New codes

D9244 in-office administration of minimal sedation – single drug – enteral

Coding tip: CDT code D9244 was created to address the limitations of the now-deleted D9248. It is used to report minimal sedation administered through the GI tract (e.g., orally) in a dental office, either as a single dose or in divided doses. Nitrous oxide may be used alongside the enteral drug to enhance the sedation effect, but its use is not mandatory.

D9245 administration of moderate sedation – enteral

Coding tip: CDT code D9245 is used to report moderate sedation administered through the GI tract (e.g., orally), either as a single dose or as multiple drugs or doses. Nitrous oxide may be used alongside the enteral drug to enhance the sedation effect, but its use is not mandatory.

D9246 administration of moderate sedation – nonintravenous parenteral – first 15 minute increment, or any portion thereof

Coding tip: CDT code D9246 is reported for the first 15 minutes of moderate sedation administered via non-intravenous and non-enteral routes, such as intramuscular, intrabony, subcutaneous or intranasal. Nitrous oxide may be used with the parenteral drug to enhance the sedation effect, but it is not mandatory.

D9247 administration of moderate sedation – non-intravenous parenteral – each subsequent 15 minute increment, or any portion thereof

Coding tip: CDT code D9247 may be used to report each additional 15-minute increment of moderate sedation administered via non-intravenous and non-enteral routes, such as intramuscular, intrabony, subcutaneous or intranasal.

D9224 administration of general anesthesia with advanced airway – first 15 minute increment, or any portion thereof

Coding tip: CDT code D9224 is used to report general anesthesia when an advanced airway is used. To report this code, two conditions must be met: the provider must administer general anesthesia, and an advanced airway must be used. Other adjunct airway methods – such as oral pharyngeal and nasal pharyngeal airways – should be reported as D9222/D9223.

D9225 administration of general anesthesia with advanced airway – each subsequent 15 minute increment, or any portion thereof

Coding tip: CDT code D9225 is reported for each subsequent 15-minute increment of general anesthesia with advanced airway.

V. USING DENTAL CODES ON MEDICAL CLAIMS

To reiterate, CDT codes may be reported to medical carriers on the CMS 1500 claim form. This is because CDT falls under the HCPCS Level II code set and is recognized under HIPAA Administrative Simplification provisions as an adopted standard for coding healthcare

services and procedures. In fact, some medical payers may direct an OMS to use CDT codes to report their services, under certain circumstances. For instance, when a CPT code does not exist that accurately describes the procedure that was rendered (e.g., the removal of impacted third molars). In such cases, a payer also may request the use of CDT anesthesia codes. It is important to note, however, that HIPAA regulations do not govern individual payer policies for reporting, claims adjudication or reimbursement for certain services or codes.

The presence of an anesthesia code or any procedure code does not guarantee payment for these services. It is crucial for the OMS and professional coding and billing staff to understand the intricacies of reimbursement for anesthesia services by each carrier, managed care organization and Medicare.

Note: The list of CDT and CPT codes in this coding paper is not all-inclusive. AAOMS recommends reporting codes applicable to the service(s) rendered and the patient's specific clinical condition as determined by the provider.

This paper should not be used as the sole reference in coding. Both diagnosis and treatment codes change frequently, and insurance carriers may differ in their interpretations of the codes.

Coding and billing decisions are personal choices to be made by individual oral and maxillofacial surgeons exercising their own professional judgment in each situation. The information provided in this paper is intended for educational purposes only. In no event shall AAOMS be liable for any decision made or action taken or not taken by anyone in reliance on the information contained in this article. For practice, financial, accounting, legal or other professional advice, professional advisers should be consulted.

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This is one in a series of AAOMS papers designed to provide information on coding claims for oral and maxillofacial surgery. This paper is to aid the oral and maxillofacial surgeon with proper treatment (CPT/CDT) coding for anesthesia services. When indicated, a reference to the appropriate area of the coding books where the principles of coding illustrated in this paper may be applied.

Proper coding provides a uniform language to describe medical, surgical and dental services. Diagnostic and procedure codes are regularly updated or revised. The AAOMS Committee on Healthcare Policy, Coding and Reimbursement has developed these coding guidelines to assist the membership in using the coding systems effectively and efficiently.

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Revised January 2026