CMS Manual System	**Department of Health & Human Services**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services**
Transmittal 1859	**Date: November 20, 2009**
	Change Request 6706

SUBJECT: MIPPA Section 139 Teaching Anesthesiologists

I. SUMMARY OF CHANGES: This Change Request implements Section 139 of MIPPA. The policies to implement MIPPA Section 139 are included as part of the CY 2010 final physician fee schedule regulation published in the Federal Register in November 2010.

We have also revised and replaced the previous Section 16003 "Anesthesia Services and Teaching CRNAs" which was only in the Paper-Based Manuals in Publication 14, The Carriers Manual, Part 3-Claims Process. This section is now Section 140.5.

New / Revised Material
Effective Date: This provision is effective for services furnished on or after January 1, 2010.
Implementation Date: January 4, 2010

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	Chapter / Section / Subsection / Title
R	12/Table of Contents/
R	12/50/Payment for Anesthesiology Services
R	12/100/100.1.2/Surgical Procedures
N	12/140/140.5/Payment for Anesthesia Services Furnished by a Teaching CRNA

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment – Business Requirements

Pub. 100-04	Transmittal: 1859	Date: November 20, 2009	Change Request: 6706

SUBJECT: MIPPA Section 139 Teaching Anesthesiologists

Effective Date: For services furnished on or after January 1, 2010

Implementation Date: January 4, 2010

I. GENERAL INFORMATION

A. Background: The proposed policies to implement Section 139 of the MIPPA were included as part of the 2010 proposed physician fee schedule published in the Federal Register on July 13, 2009. Section 139 establishes a special payment rule for teaching anesthesiologists and provides a directive to the Secretary regarding payments for the services of teaching certified registered nurse anesthetists. It also specifies the periods when the teaching anesthesiologist must be present during the procedure in order to receive payment for the case at 100 percent of the anesthesia fee schedule amount (the regular fee schedule rate). This provision is effective for services furnished on or after January 1, 2010.

B. Policy: For anesthesia services furnished prior to January 1, 2010, payment for the services of an anesthesiologist involved in cases with anesthesia residents was determined as follows. If the teaching anesthesiologist was involved in a single case with an anesthesia resident, and the physician satisfied the criteria in Pub. 100-04, Chapter 12, §100.1, then payment could be made based on the anesthesia fee schedule. The fee schedule amount would be the same as if the anesthesiologist performed the anesthesia case alone. If the anesthesiologist medically directed the provision of anesthesia services in two, three or four concurrent cases, and any of the concurrent cases involved residents, then payment was made for the physician's involvement in the resident case(s) under the medical direction payment policy. Under medical direction, payment for the anesthesiologist service is based on 50 percent of the anesthesia fee schedule that would apply if the anesthesiologist performed the case alone.

Effective for services furnished on or after January 1, 2010, payment may be made under Section 139 of MIPPA based on the regular fee schedule amount for the teaching anesthesiologist's involvement in the training of residents in either a single anesthesia case or two concurrent anesthesia cases. We are also applying this same policy if the teaching anesthesiologist is involved in one resident case that is concurrent to another case that is paid under the medical direction payment rules. However, the medical direction payment policy would apply to the concurrent case involving the certified registered nurse anesthetist (CRNA), anesthesiologist assistant (AA) or student nurse anesthetist.

In order for the special payment rule for teaching anesthesiologists to apply, the teaching anesthesiologist (or different anesthesiologists in the same physician group) must be present during all critical or key portions of the anesthesia service. Where different teaching anesthesiologists in the anesthesia group are present during the key or critical periods, the performing physician, for purposes of claims reporting, is the teaching anesthesiologist who started the case. The teaching anesthesiologist (or another anesthesiologist with whom the teaching anesthesiologist has entered into an arrangement) must be immediately available to furnish anesthesia services during the entire procedure.

For anesthesia services furnished prior to January 1, 2010, payment for the services of a teaching CRNA, not under the medical direction of a physician, involved with one student nurse anesthetist or in two concurrent

anesthesia cases involving student nurse anesthetists was determined as follows. If the teaching CRNA, not under the medical direction of a physician, was involved in a single case with a student nurse anesthetist and present with the student throughout the case, payment was made at the regular fee schedule rate. If the teaching CRNA, who is not under the medical direction of a physician, is involved in two concurrent student nurse anesthetist cases, payment could be made based on the full base units and partial time units. To bill the base units, the teaching CRNA must be present with the student nurse anesthetist during the pre and post anesthesia care for each of the two cases involving student nurse anesthetists. The teaching CRNA could bill for time for each case based on the actual amount of time present with the student nurse anesthetist.

The payment policy for the teaching CRNA in the single student nurse anesthetist case remains unchanged for services furnished on or after January 1, 2010. However, under Section 139, the teaching CRNA can be paid the full fee for his/her involvement in each of two concurrent anesthesia cases with student nurse anesthetists. To bill the base units, the teaching CRNA must be present with the student nurse anesthetist during the pre and post anesthesia care for each of the two cases involving student nurse anesthetists. The teaching CRNA must continue to devote his or her time to the two concurrent student nurse anesthetist cases and not be involved in other activities. The teaching CRNA can decide how to allocate his or her time to optimize patient care in the two cases based on the complexity of the anesthesia case, the experience and skills of the student nurse anesthetist, the patient's health status and other factors.

No new payment modifiers are being created to describe the services of teaching anesthesiologists or teaching CRNAs. Both teaching anesthesiologists and teaching CRNAs should continue to report their anesthesia services using the existing anesthesia payment modifiers.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6706.1	The contractor shall instruct the teaching anesthesiologist to use the AA modifier to report anesthesia services furnished on or after January 1, 2010, if the teaching anesthesiologist meets the conditions of 6706.2 and is involved in the training of residents in a single anesthesia case.	X			X						
6706.1.1	The contractor shall instruct the teaching anesthesiologist to use the AA modifier to report anesthesia services furnished on or after January 1, 2010, if the teaching anesthesiologist meets the conditions of 6706.2 and is involved in two concurrent resident cases.	X			X						
6706.1.2	The contractor shall instruct the teaching anesthesiologist to use the AA modifier to report anesthesia services furnished on or after January 1,	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	2010, if the teaching anesthesiologist meets the conditions of 6706.2 and is involved in one resident case concurrent to another case paid under the medical direction payment policy.										
6706.2	The contractor shall educate anesthesiologists that the teaching anesthesiologist (or different anesthesiologists in the same physician group) must be present with the resident during all critical or key portions of the anesthesia service. The teaching anesthesiologist (or another teaching anesthesiologist with whom the teaching anesthesiologist has entered into an arrangement) must be immediately available to furnish services during the entire procedure.	X			X						
6706.3	The contractor shall educate the teaching anesthesiologists to use the GC certification modifier to certify that he/she complies with the teaching anesthesiologist's provisions in 6706.2 in addition to billing the AA modifier.	X			X						
6706.4	The contractor shall instruct the teaching CRNA, who is not under the medical direction of a physician, and is involved with two concurrent cases involving student nurse anesthetist furnished on or after January 1, 2010, to report these cases with the QZ modifier.	X			X						
6706.4.1	The contractor shall instruct the teaching CRNA, who is not under the medical direction of a physician, that to qualify to bill anesthesia base units or anesthesia time for each of the two concurrent cases involving student nurse anesthetists, the CRNA must meet the conditions in 6706.4.2 and 6706.4.3.	X			X						
6706.4.2	The contractor shall instruct the teaching CRNA that to bill the anesthesia base units for each concurrent case, the teaching CRNA must be present with each student nurse anesthetist during the pre and post anesthesia care.	X			X						
6706.4.3	The contractor shall instruct the teaching CRNA that to bill anesthesia time for each case, the teaching CRNA must continue to devote his/her time to the two concurrent cases and not be involved in other anesthesia cases.	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6706.5	The contractor shall educate the provider via the MLN article that the performing NPI of the teaching anesthesiologist who started the case must be indicated in the appropriate field on the claim if more than one teaching anesthesiologist in the anesthesia group is present during the key or critical periods. A teaching anesthesiologist in a group practice would put his/her NPI in field #24 (as the rendering physician) and the NPI of the group would go in field # 33.	X			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
6706.6	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X			X						

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: None

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X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: None

V. CONTACTS

Pre-Implementation Contact(s): Jim Menas 410-786-4507

Post-Implementation Contact(s): Regional Office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual
Chapter 12 - Physicians/Nonphysician Practitioners

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(Rev.1859, 11-20-09)

50 - Payment for Anesthesiology Services

(Rev. 1859; Issued: 11-20-09; Effective Date: For services furnished on or after 01-01-10; Implementation Date: 01-04-10)

A. General Payment Rule

The fee schedule amount for physician anesthesia services furnished on or after January 1, 1992 is, with the exceptions noted, based on allowable base and time units multiplied by an anesthesia conversion factor specific to that locality. The base unit for each anesthesia procedure is communicated to the *Part B Contractors* by means of the HCPCS file released annually. The public can access the base units on the CMS homepage through the anesthesiologist's center. The way in which time units are calculated is described in §50.G. CMS releases the conversion factor annually.

B. Payment at Personally Performed Rate

The *Part B Contractor* must determine the fee schedule payment, recognizing the base unit for the anesthesia code and one time unit per 15 minutes of anesthesia time if:

- The physician personally performed the entire anesthesia service alone;
- The physician is involved with one anesthesia case with a resident, the physician is a teaching physician as defined in §100, and the service is furnished on or after January 1, 1996;
- *The physician is involved in the training of physician residents in a single anesthesia case, two concurrent anesthesia cases involving residents or a single anesthesia case involving a resident that is concurrent to another case paid under the medical direction rules. The physician meets the teaching physician criteria in §100.1.4 and the service is furnished on or after January 1, 2010;*
- The physician is continuously involved in a single case involving a student nurse anesthetist;
- The physician is continuously involved in one anesthesia case involving a CRNA (or AA) and the service was furnished prior to January 1, 1998. If the physician is involved with a single case with a CRNA (or AA) and the service was furnished on or after January 1, 1998, carriers may pay the physician service and the CRNA (or AA) service in accordance with the medical direction payment policy; or
- The physician and the CRNA (or AA) are involved in one anesthesia case and the services of each are found to be medically necessary. Documentation must be submitted by both the CRNA and the physician to support payment of the full fee for each of the two providers. The physician reports the "AA" modifier and the CRNA reports the "QZ" modifier for a nonmedically directed case.

C. Payment at the Medically Directed Rate

The Part B Contractor determines payment for the physician's medical direction service furnished on or after January 1, 1998, on the basis of 50 percent of the allowance for the service performed by the physician alone. Medical direction occurs if the physician medically directs qualified individuals in two, three, or four concurrent cases and the physician performs the following activities.

- Performs a pre-anesthetic examination and evaluation;
- Prescribes the anesthesia plan;
- Personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence;
- Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist;
- Monitors the course of anesthesia administration at frequent intervals;
- Remains physically present and available for immediate diagnosis and treatment of emergencies; and
- Provides indicated-post-anesthesia care.

Prior to January 1, 1999, the physician was required to participate in the most demanding procedures of the anesthesia plan, including induction and emergence.

For medical direction services furnished on or after January 1, 1999, the physician must participate only in the most demanding procedures of the anesthesia plan, including, if applicable, induction and emergence. Also for medical direction services furnished on or after January 1, 1999, the physician must document in the medical record that he or she performed the pre-anesthetic examination and evaluation. Physicians must also document that they provided indicated post-anesthesia care, were present during some portion of the anesthesia monitoring, and were present during the most demanding procedures, including induction and emergence, where indicated.

For services furnished on or after January 1, 1994, the physician can medically direct two, three, or four concurrent procedures involving qualified individuals, all of whom could be CRNAs, AAs, interns, residents or combinations of these individuals. The medical direction rules apply to cases involving student nurse anesthetists if the physician directs two concurrent cases, each of which involves a student nurse anesthetist, or the physician directs one case involving a student nurse anesthetist and another involving a CRNA, AA, intern or resident.

For services furnished on or after January 1, 2010, the medical direction rules do not apply to a single resident case that is concurrent to another anesthesia case paid under the medical direction rules or to two concurrent anesthesia cases involving residents.

If anesthesiologists are in a group practice, one physician member may provide the pre-anesthesia examination and evaluation while another fulfills the other criteria. Similarly, one physician member of the group may provide post-anesthesia care while another member of the group furnishes the other component parts of the anesthesia service. However, the medical record must indicate that the services were furnished by physicians and identify the physicians who furnished them.

A physician who is concurrently directing the administration of anesthesia to not more than four surgical patients cannot ordinarily be involved in furnishing additional services to other patients. However, addressing an emergency of short duration in the immediate area, administering an epidural or caudal anesthetic to ease labor pain, or periodic, rather than continuous, monitoring of an obstetrical patient does not substantially diminish the scope of control exercised by the physician in directing the administration of anesthesia to surgical patients. It does not constitute a separate service for the purpose of determining whether the medical direction criteria are met. Further, while directing concurrent anesthesia procedures, a physician may receive patients entering the operating suite for the next surgery, check or discharge patients in the recovery room, or handle scheduling matters without affecting fee schedule payment.

However, if the physician leaves the immediate area of the operating suite for other than short durations or devotes extensive time to an emergency case or is otherwise not available to respond to the immediate needs of the surgical patients, the physician's services to the surgical patients are supervisory in nature. Carriers may not make payment under the fee schedule.

See §50.J for a definition of concurrent anesthesia procedures.

D. Payment at Medically Supervised Rate

The Part B Contractor may allow only three base units per procedure when the anesthesiologist is involved in furnishing more than four procedures concurrently or is performing other services while directing the concurrent procedures. An additional time unit may be recognized if the physician can document he or she was present at induction.

E. Billing and Payment for Multiple Anesthesia Procedures

Physicians bill for the anesthesia services associated with multiple bilateral surgeries by reporting the anesthesia procedure with the highest base unit value with the multiple procedure modifier "-51." They report the total time for all procedures in the line item with the highest base unit value.

If the same anesthesia CPT code applies to two or more of the surgical procedures, billers enter the anesthesia code with the "-51" modifier and the number of surgeries to which the modified CPT code applies.

Payment can be made under the fee schedule for anesthesia services associated with multiple surgical procedures or multiple bilateral procedures. Payment is determined based on the base unit of the anesthesia procedure with the highest base unit value and time units based on the actual anesthesia time of the multiple procedures. See §§40.6-40.7 for a definition and appropriate billing and claims processing instructions for multiple and bilateral surgeries.

F. Payment for Medical and Surgical Services Furnished in Addition to Anesthesia Procedure

Payment may be made under the fee schedule for specific medical and surgical services furnished by the anesthesiologist as long as these services are reasonable and medically necessary or provided that other rebundling provisions (see §30 and Chapter 23) do not preclude separate payment. These services may be furnished in conjunction with the anesthesia procedure to the patient or may be furnished as single services, e.g., during the day of or the day before the anesthesia service. These services include the insertion of a Swan Ganz catheter, the insertion of central venous pressure lines, emergency intubation, and critical care visits.

G. Anesthesia Time and Calculation of Anesthesia Time Units

Anesthesia time is defined as the period during which an anesthesia practitioner is present with the patient. It starts when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the patient, that is, when the patient may be placed safely under postoperative care. Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service. In counting anesthesia time for services furnished on or after January 1, 2000, the anesthesia practitioner can add blocks of time around an interruption in anesthesia time as long as the anesthesia practitioner is furnishing continuous anesthesia care within the time periods around the interruption.

Actual anesthesia time in minutes is reported on the claim. For anesthesia services furnished on or after January 1, 1994, the A/B MAC computes time units by dividing reported anesthesia time by 15 minutes. Round the time unit to one decimal place. The A/B MAC does not recognize time units for CPT codes 01995 or 01996.

For purposes of this section, anesthesia practitioner means a physician who performs the anesthesia service alone, a CRNA who is not medically directed, or a CRNA or AA, who is medically directed. The physician who medically directs the CRNA or AA would ordinarily report the same time as the CRNA or AA reports for the CRNA service.

H. Base Unit Reduction for Concurrent Medically Directed Procedures

If the physician medically directs concurrent medically directed procedures prior to January 1, 1994, reduce the number of base units for each concurrent procedure as follows.

- For two concurrent procedures, the base unit on each procedure is reduced 10 percent.

- For three concurrent procedures, the base unit on each procedure is reduced 25 percent.

- For four concurrent procedures, the base on each concurrent procedure is reduced 40 percent.

- If the physician medically directs concurrent procedures prior to January 1, 1994, and any of the concurrent procedures are cataract or iridectomy anesthesia, reduce the base units for each cataract or iridectomy procedure by 10 percent.

I. Monitored Anesthesia Care

The *Part B Contractor* pays for reasonable and medically necessary monitored anesthesia care services on the same basis as other anesthesia services. Anesthesiologists use modifier QS to report monitored anesthesia care cases. Monitored anesthesia care involves the intra-operative monitoring by a physician or qualified individual under the medical direction of a physician or of the patient's vital physiological signs in anticipation of the need for administration of general anesthesia or of the development of adverse physiological patient reaction to the surgical procedure. It also includes the performance of a pre-anesthetic examination and evaluation, prescription of the anesthesia care required, administration of any necessary oral or parenteral medications (e.g., atropine, demerol, valium) and provision of indicated postoperative anesthesia care.

Payment is made under the fee schedule using the payment rules in subsection B if the physician personally performs the monitored anesthesia care case or under the rules in subsection C if the physician medically directs four or fewer concurrent cases and monitored anesthesia care represents one or more of these concurrent cases.

J. Definition of Concurrent Medically Directed Anesthesia Procedures

Concurrency is defined with regard to the maximum number of procedures that the physician is medically directing within the context of a single procedure and whether these other procedures overlap each other. Concurrency is not dependent on each of the cases involving a Medicare patient. For example, if an anesthesiologist directs three concurrent procedures, two of which involve non-Medicare patients and the remaining a Medicare patient, this represents three concurrent cases. The following example illustrates this concept and guides physicians in determining how many procedures they are directing.

EXAMPLE

Procedures A through E are medically directed procedures involving CRNAs and furnished between January 1, 1992 and December 31, 1997 (1998 concurrent instructions can be found in subsection C.) The starting and ending times for each procedure represent the periods during which anesthesia time is counted. Assume that none of the procedures were cataract or iridectomy anesthesia.

Procedure A begins at 8:00 a.m. and lasts until 8:20 a.m.

Procedure B begins at 8:10 a.m. and lasts until 8:45 a.m.
Procedure C begins at 8:30 a.m. and lasts until 9:15 a.m.
Procedure D begins at 9:00 a.m. and lasts until 12:00 noon.
Procedure E begins at 9:10 a.m. and lasts until 9:55 a.m.

Procedure	Number of Concurrent Medically Directed Procedures	Base Unit Reduction Percentage
A	2	10%
B	2	10%
C	3	25%
D	3	25%
E	3	25%

From 8:00 a.m. to 8:20 a.m., the length of procedure A, the anesthesiologist medically directed two concurrent procedures, A and B.

From 8:10 a.m. to 8:45 a.m., the length of procedure B, the anesthesiologist medically directed two concurrent procedures. From 8:10 to 8:20 a.m., the anesthesiologist medically directed procedures A and B. From 8:20 to 8:30 a.m., the anesthesiologist medically directed only procedure B. From 8:30 to 8:45 a.m., the anesthesiologist medically directed procedures B and C. Thus, during procedure B, the anesthesiologist medically directed, at most, two concurrent procedures.

From 8:30 a.m. to 9:15 a.m., the length of procedure C, the anesthesiologist medically directed three concurrent procedures. From 8:30 to 8:45 a.m., the anesthesiologist medically directed procedures B and C. From 8:45 to 9:00 a.m., the anesthesiologist medically directed procedure C. From 9:00 to 9:10 a.m., the anesthesiologist medically directed procedures C and D. From 9:10 to 9:15 a.m., the anesthesiologist medically directed procedures C, D and E. Thus, during procedure C, the anesthesiologist medically directed, at most, three concurrent procedures.

The same analysis shows that during procedure D or E, the anesthesiologist medically directed, at most, three concurrent procedures.

K. Anesthesia Claims Modifiers

Physicians report the appropriate anesthesia modifier to denote whether the service was personally performed, medically directed, or medically supervised.

Specific anesthesia modifiers include:

AA - Anesthesia Services performed personally by the anesthesiologist;

AD - Medical Supervision by a physician; more than 4 concurrent anesthesia procedures;

G8 - Monitored anesthesia care (MAC) for deep complex complicated, or markedly invasive surgical procedures;

G9 - Monitored anesthesia care for patient who has a history of severe cardio-pulmonary condition;

QK - Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals;

QS - Monitored anesthesia care service;

QX - CRNA service; with medical direction by a physician;

QY - Medical direction of one certified registered nurse anesthetist by an anesthesiologist;

QZ - CRNA service: without medical direction by a physician; and

GC - these services have been performed by a resident under the direction of a teaching physician.

The GC modifier is reported by the teaching physician to indicate he/she rendered the service in compliance with the teaching physician requirements in §100.1.2. One of the payment modifiers must be used in conjunction with the GC modifier.

The QS modifier is for informational purposes. Providers must report actual anesthesia time on the claim.

The *Part B Contractor* must determine payment for anesthesia in accordance with these instructions. They must be able to determine the uniform base unit that is assigned to the anesthesia code and apply the appropriate reduction where the anesthesia procedure is medically directed. They must also be able to determine the number of anesthesia time units from actual anesthesia time reported on the claim. The *Part B Contractor* must multiply allowable units by the anesthesia-specific conversion factor used to determine fee schedule payment for the payment area.

L. Anesthesia and Medical/Surgical Service Provided by the Same Physician

Anesthesia services range in complexity. The continuum of anesthesia services, from least intense to most intense in complexity is as follows: local or topical anesthesia, moderate (conscious) sedation, regional anesthesia and general anesthesia. Prior to 2006, Medicare did not

recognize separate payment if the same physician provided the medical or surgical procedure and the anesthesia needed for the procedure.

Moderate sedation is a drug induced depression of consciousness during which the patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. Moderate sedation does not include minimal sedation, deep sedation or monitored anesthesia care. In 2006, the CPT added new codes 99143 to 99150 for moderate or conscious sedation. The moderate (conscious) sedation codes are carrier priced under the Medicare physician fee schedule.

The CPT codes 99143 to 99145 describe moderate sedation provided by the same physician 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. The physician can bill the conscious sedation codes 99143 to 99145 as long as the procedure with it is billed is not listed in Appendix G of CPT. CPT codes 99148 to 99150 describe moderate sedation provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports.

The CPT includes Appendix G, Summary of CPT Codes That Include Moderate (Conscious) Sedation. This appendix lists those procedures for which moderate (conscious) sedation is an inherent part of the procedure itself. CPT coding guidelines instruct practices not to report CPT codes 99143 to 99145 in conjunction with codes listed in Appendix G. The National Correct Coding Initiative has established edits that bundle CPT codes 99143 and 99144 into the procedures listed in Appendix G.

In the unusual event when a second physician other than the health care professional performing the diagnostic or therapeutic services provides moderate sedation in the facility setting for the procedures listed in Appendix G, the second physician can bill 99148 to 99150. The term, facility, includes those places of service listed in Chapter 23 Addendum -- field 29. However, when these services are performed by the second physician in the nonfacility setting, CPT codes 99148 to 99150 are not to be reported.

If the anesthesiologist or CRNA provides anesthesia for diagnostic or therapeutic nerve blocks or injections and a different provider performs the block or injection, then the anesthesiologist or CRNA may report the anesthesia service using CPT code 01991. The service must meet the criteria for monitored anesthesia care. If the anesthesiologist or CRNA provides both the anesthesia service and the block or injection, then the anesthesiologist or CRNA may report the anesthesia service using the conscious sedation code and the injection or block. However, the anesthesia service must meet the requirements for conscious sedation and if a lower level complexity anesthesia service is provided, then the conscious sedation code should not be reported.

If the physician performing the medical or surgical procedure also provides a level of anesthesia lower in intensity than moderate or conscious sedation, such as a local or topical anesthesia, then the conscious sedation code should not be reported and no payment should be allowed by the

carrier. There is no CPT code for the performance of local anesthesia and as payment for this service is considered in the payment for the underlying medical or surgical service.

100.1.2 - Surgical Procedures

(Rev. 1859; Issued: 11-20-09; Effective Date: For services furnished on or after 01-01-10; Implementation Date: 01-04-10)

In order to bill for surgical, high-risk, or other complex procedures, the teaching physician must be present during all critical and key portions of the procedure and be immediately available to furnish services during the entire procedure.

A. Surgery (Including Endoscopic Operations)

The teaching surgeon is responsible for the preoperative, operative, and postoperative care of the beneficiary. The teaching physician's presence is not required during the opening and closing of the surgical field unless these activities are considered to be critical or key portions of the procedure. The teaching surgeon determines which postoperative visits are considered key or critical and require his or her presence. If the postoperative period extends beyond the patient's discharge and the teaching surgeon is not providing the patient's follow-up care, then instructions on billing for less than the global package in §40 apply. During non-critical or non-key portions of the surgery, if the teaching surgeon is not physically present, he/she must be immediately available to return to the procedure, i.e., he/she cannot be performing another procedure. If circumstances prevent a teaching physician from being immediately available, then he/she must arrange for another qualified surgeon to be immediately available to assist with the procedure, if needed.

1. Single Surgery

When the teaching surgeon is present for the entire surgery, his or her presence may be demonstrated by notes in the medical records made by the physician, resident, or operating room nurse. For purposes of this teaching physician policy, there is no required information that the teaching surgeon must enter into the medical records.

2. Two Overlapping Surgeries

In order to bill Medicare for two overlapping surgeries, the teaching surgeon must be present during the critical or key portions of both operations. Therefore, the critical or key portions may not take place at the same time. When all of the key portions of the initial procedure have been completed, the teaching surgeon may begin to become involved in a second procedure. The teaching surgeon must personally document in the medical record that he/she was physically present during the critical or key portion(s) of both procedures. When a teaching physician is not present during non-critical or non-key portions of the procedure and is participating in another surgical procedure, he/she must arrange for another qualified surgeon to immediately assist the resident in the other case should the need arise. In the case of three concurrent surgical procedures, the role of the teaching surgeon (but not anesthesiologist) in each of the cases is classified as a supervisory service to the hospital rather than a physician service to an individual patient and is not payable under the physician fee schedule.

3. Minor Procedures

For procedures that take only a few minutes (five minutes or less) to complete, e.g., simple suture, and involve relatively little decision making once the need for the operation is determined, the teaching surgeon must be present for the entire procedure in order to bill for the procedure.

4. Anesthesia

Medicare pays at *the regular fee schedule level* if a teaching anesthesiologist is involved in a single procedure with one resident. The teaching physician must document in the medical records that he/she was present during all critical (or key) portions of the procedure. The teaching physician's physical presence during only the preoperative or postoperative visits with the beneficiary is not sufficient to receive Medicare payment. If an anesthesiologist is involved in concurrent procedures with more than one resident or with a resident and a nonphysician anesthetist *and the service is furnished prior to January 1, 2010*, Medicare pays for the anesthesiologist's services as medical direction.

In those cases where the teaching anesthesiologist is involved in two concurrent anesthesia cases with residents on or after January 1, 2004, the teaching anesthesiologist may bill the usual base units and anesthesia time for the amount of time he/she is present with the resident. The teaching anesthesiologist can bill base units if he/she is present with the resident throughout pre and post anesthesia care. The teaching anesthesiologist should use the "AA" modifier to report such cases. The teaching anesthesiologist must document his/her involvement in cases with residents. The documentation must be sufficient to support the payment of the fee and available for review upon request.

For anesthesia services furnished on or after January 1, 2010, payment may be made under the Medicare physician fee schedule at the regular fee schedule level if the teaching anesthesiologist is involved in the training of a resident in a single anesthesia case, two concurrent anesthesia cases involving residents, or a single anesthesia case involving a resident that is concurrent to another case paid under the medical direction rules. To qualify for payment, the teaching anesthesiologist, or different anesthesiologists in the same anesthesia group, must be present during all critical or key portions of the anesthesia service or procedure involved. The teaching anesthesiologist (or another anesthesiologist with whom the teaching physician has entered into an arrangement)must be immediately available to furnish anesthesia services during the entire procedure. The documentation in the patient's medical records must indicate the teaching physician's presence during all critical or key portions of the anesthesia procedure and the immediate availability of another teaching anesthesiologist as necessary.

If different teaching anesthesiologists are present with the resident during the key or critical periods of the resident case, the NPI of the teaching anesthesiologist who started the case must be indicated in the appropriate field on the claim form.

The teaching anesthesiologist should use the "AA" modifier and the "GC" certification modifier to report such cases. See §50 B. and §0 K.

5. Endoscopy Procedures

To bill Medicare for endoscopic procedures (excluding endoscopic surgery that follows the surgery policy in subsection A, above), the teaching physician must be present during the entire viewing. The entire viewing starts at the time of insertion of the endoscope and ends at the time of removal of the endoscope. Viewing of the entire procedure through a monitor in another room does not meet the teaching physician presence requirement.

140.5 - Payment for Anesthesia Services Furnished by a Teaching CRNA

(Rev. 1859; Issued: 11-20-09; Effective Date: For services furnished on or after 01-01-10; Implementation Date: 01-04-10)

*Payment can be made under Part B to a teaching CRNA who supervises a single case involving a student nurse anesthetist where the CRNA is continuously present. The CRNA reports the service using the usual "QZ" modifier. This modifier designates that the teaching CRNA is **not** medically directed by an anesthesiologist. No payment is made under Part B for the service provided by a student nurse anesthetist.*

The American Association of Nurse Anesthetists (AANA) indicates that their standards for approved nurse anesthetist training programs allow teaching CRNAs to supervise two concurrent cases involving student nurse anesthetists. You may allow payment, as follows, if a teaching CRNA is involved with two student nurse anesthetists and the service is furnished on or after August 1, 2002:

- *Recognize the full base units (assigned to the anesthesia code) where the teaching CRNA is present with the student nurse anesthetist throughout pre and post anesthesia care; and*

- *Recognize the actual time the teaching CRNA is personally present with the student nurse anesthetist. Anesthesia time may be discontinuous. For example, a teaching CRNA is involved in two concurrent cases with student nurse anesthetists. Case 1 runs from 9:00 a.m. to 11:00 a.m. and case 2 runs from 9:45 a.m. to 11:30 a.m.. The teaching CRNA is present in case 1 from 9:00 a.m. to 9:30 a.m. and from 10:15 a.m. to 10:30 a.m.. From 9:45 a.m. to 10:14 a.m. and from 10:31 a.m. to 11:30 a.m., the CRNA is present in case 2. The CRNA may report 45 minutes of anesthesia time for case 1 (i.e., 3 time units) and 88 minutes (i.e., 5.9 units) of anesthesia time for case 2.*

The teaching CRNA must document his/her involvement in cases with student nurse anesthetists. The documentation must be sufficient to support the payment of the fee and available for review upon request.

For services furnished on or after January 1, 2010, the teaching CRNA, not under the medical direction of a physician, can be paid for his/her involvement in each of two concurrent cases with student nurse anesthetists. Allow payment at the regular fee schedule rate if the teaching CRNA is involved with two concurrent student nurse anesthetist cases. The CRNA reports the anesthesia service using the "QZ" modifier.

To bill the anesthesia base units, instruct the CRNA that he/she must be present with the student nurse anesthetist during the pre and post anesthesia care for each of the two cases.

To bill anesthesia time for each case, instruct the teaching CRNA that he/she must continue to devote his/her time to the two concurrent cases and not be involved in other activities. The teaching CRNA can decide how to allocate his or her time to optimize patient care in the two cases based on the complexity of the anesthesia case, the experience and skills of the student nurse anesthetist, the patient's health status and other factors.

The teaching CRNA must document his/her involvement in the cases with the student nurse anesthetists.