CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1324	**Date: AUGUST 27, 2007**
	Change Request 5618

NOTE: This transmittal replaces Transmittal 1316, dated August 17, 2007. Business requirement 5618.4.1 incorrectly referred to Medicare Summary Message (MSN) 16.8. It now refers to MSN 16.45. In the Background section of the Business Requirements, the last sentence in the fourth paragraph was misplaced. This sentence now appears as the second sentence in that paragraph.

Subject: Anesthesia Services Furnished by the Same Physician Providing the Medical and Surgical Service

I. SUMMARY OF CHANGES: The anesthesia policy in section 50 of Chapter 12 is being revised so that it is consistent with the pricing of conscious sedation codes under the Medicare physician fee schedule and CPT coding guidelines. New language has been added that explains the payment policy if the same physician performs the medical/surgical service and the conscious sedation service. Exhibit 1 that lists the base units by anesthesia code is being deleted. This exhibit is out of date and the material is communicated to the carriers annually via the HCPCS file.

New / Revised Material
Effective Date: January 1, 2006
Implementation Date: October 1, 2007

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

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	12/50/General Payment for Anesthesiology Services

III. FUNDING:
No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2007 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 1324	Date: August 27, 2007	Change Request: 5618

NOTE: This transmittal replaces Transmittal 1316, dated August 17, 2007. Business requirement 5618.4.1 incorrectly referred to Medicare Summary Message (MSN) 16.8. It now refers to MSN 16.45. In the Background section of the Business Requirements, the last sentence in the fourth paragraph was misplaced. This sentence now appears as the second sentence in that paragraph.

SUBJECT: Anesthesia Services Furnished by the Same Physician Providing the Medical or Surgical Service

Effective Date: **January 1, 2006**
Implementation Date: October 1, 2007

I. GENERAL INFORMATION

A. Background: Section 50 A. of Chapter 12 of the Pub 100-04 addressed the general payment rules for physician anesthesia services paid under the physician fee schedule.

This section instructed the carriers not to allow separate payment for the anesthesia service performed by the physician who also furnishes the medical or surgical services. It pointed out, for example, that the carriers may not allow separate payment for the surgeon's performance of a local or surgical anesthesia if the surgeon also performs the surgical procedure. Similarly, separate payment is not allowed for the psychiatrist's performance of the anesthesia service associated with the electroconvulsive therapy if the psychiatrist performs the electroconvulsive therapy.

In 2006, the CPT added new codes for moderate (conscious sedation). These are CPT codes 99143 to 99150. Moderate sedation is a drug induced depression of consciousness during which patients respond 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.

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 code as long as the procedure with which it is billed is not listed in Appendix G of 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.

Appendix G, *Summary of CPT Codes That Include Moderate (Conscious) Sedation*, lists those procedures for which conscious sedation is an inherent part of the procedure itself. CPT describes the interrelationship between the appendix and the conscious sedation codes.

CPT coding guidelines instruct practices not to report Codes 99143 to 99145 in conjunction with codes listed in Appendix G. The National Correct Coding Initiative added edits in April 2006 that bundled CPT codes 99143 and 99144 into the procedures listed in Appendix G. (There are no edits for code 99145; it is an add-on-code and it is not paid if the primary code is not paid.)

In the unusual event when a second physician other than the health care professional performing the diagnostic or therapeutic services provides moderation sedation in the facility setting for the procedures listed in Appendix

G, the second physician can bill 99148 to 99150. However, when these services are performed by the second physician in the nonfacility setting, codes 99148 to 99150 are not to be reported.

Since 2006, the conscious sedation codes have been assigned a status indicator of "C" under the physician fee schedule designating that these services are carrier priced. CMS has not established relative value units for these services.

B. Policy: The anesthesia payment policy in Pub. 100-04, chapter 12, section 50 is being revised so that it is consistent with the pricing of the conscious sedation codes under the Medicare physician fee schedule and CPT coding guidelines. The new policy is as follows:

If the physician performing the procedure also provides moderate sedation for the procedure, then payment may be made for conscious sedation consistent with CPT guidelines.

If the physician performing the procedure also provides local or minimal sedation for the procedure, then no separate payment is made for the local or minimal sedation service.

The carrier shall follow the NCCI edits imposed for codes 99143 and 99144 if billed with any procedure in Appendix G of the CPT.

The codes listed in Appendix G of the CPT are as follows:

19298, 20982, 22526, 22527, 31615, 31620, 31622, 31623, 31624, 31625, 31628, 31629, 31635, 31645, 31646, 31656, 31725, 32019, 32020, 32201, 33010, 33011, 33206, 33207, 33208, 33210, 33211, 33212, 33213, 33214, 33216, 33217, 33218, 33220, 33222, 33223, 33233, 33234, 33235, 33240, 33241, 33244, 33249, 35470, 35471, 35472, 35473, 35474, 35475, 35476, 36555, 36557, 36558, 36560, 36561, 36563, 36565, 36566, 36568, 36570, 36571, 36576, 36578, 36581, 36582, 36583, 36585, 36590, 36870, 37184, 37185, 37186, 37187, 37188, 37203, 37210, 37215, 37216, 43200, 43201, 43202, 43204, 43205, 43215, 43216, 43217, 43219, 43220, 43226, 43227, 43228, 43231, 43232, 43234, 43235, 43236, 43237, 43238, 43239, 43240, 43241, 43242, 43243, 43244, 43245, 43246, 43247, 43248, 43249, 43250, 43251, 43255, 43256, 43257, 43258, 43259, 43260, 43261, 43262, 43263, 43264, 43265, 43267, 43268, 43269, 43271, 43272, 43453, 43456, 43458, 43750, 44360, 44361, 44363, 44364, 44365, 44366, 44369, 44370, 44372, 44373, 44376, 44377, 44378, 44379, 44380, 44382, 44383, 44385, 44386, 44388, 44389, 44390, 44391, 44392, 44393, 44394, 44397, 44500, 44901, 45303, 45305, 45307, 45308, 45309, 45315, 45317, 45320, 45321, 45327, 45332, 45333, 45334, 45335, 45337, 45338, 45339, 45340, 45341, 45342, 45345, 45355, 45378, 45379, 45380, 45381, 45382, 45383, 45384, 45385, 45386, 45387, 45391, 45392, 47011, 48511, 49021, 49041, 49061, 50021, 50382, 50384, 50387, 50592, 58823, 66720, 69300, 77600, 77605, 77610, 77615, 92953, 92960, 92961, 92973, 92974, 92975, 92978, 92979, 92980, 92981, 92982, 92984, 92986, 92987,

92995, 92996, 93312, 93313, 93314, 93315, 93316, 93317, 93318, 93501, 93505, 93508, 93510, 93511, 93514, 93524, 93526, 93527, 93528, 93529, 93530, 93539, 93540, 93541, 93542, 93543, 93544, 93545, 93555, 93556, 93561, 93562, 93571, 93572, 93609, 93613, 93615, 93616, 93618, 93619, 93620, 93621, 93622, 93624, 93640, 93641, 93642, 93650, 93651, 93652.

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	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5618.1	Contractors shall instruct physicians to follow the coding guidelines in CPT, including those in Appendix G, for reporting the conscious sedation codes.	X			X							
5618.2	Contractors shall process claims for conscious sedation consistent with the status indicator of C for conscious sedation codes (99143 to 99150) under the Medicare physician fee schedule.	X			X							
5618.3	Contractors shall not allow payment for codes 99148 to 99150 if any of these codes is performed on the same day with a medical/surgical service listed in Appendix G of CPT and the service is provided for a patient in a nonfacility setting. The nonfacility setting is any setting other than a facility as listed in Pub. 100-04, chapter 23, Addendum – field 29. The term, facility, includes POS codes 21, 22, 23, 24, 26, 31, 34, 41, 42, 51, 52, 53, 56, and 61.	X			X							
5618.3.1	Contractors shall use Medicare Summary Notice (MSN) message 16.8 when the service is bundled into the other service. "Payment is included in another service received on the same day." or "El pago esta incluido en otro servicio recivido el mismo día.	X			X							
5618.3.2	Contractors shall use claim adjustment reason code 97, "Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	X			X							
5618.3.3	Contractors shall use remittance advice remark code M80, "We cannot pay for this when performed during the same session as another approved service for this beneficiary."	X			X							
5618.4	Contractors shall note that the beneficiary is not liable for payment for claims denied as stated in requirement number 5618.3.1.	X			X							
5618.4.1	Contractors shall use Medicare Summary Notice (MSN) message 16.45 the beneficiary is not liable for payment for claims denied as stated in	X			X							

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	requirement number 5618.3.1. "You cannot be billed separately for this item or service. You do not have to pay this amount." or "Usted no puede ser facturado separademente por este articulo o servicio. Usted no tiene que pagar esta cantidad."											
5618.5	Contractors shall allow payment for codes 99148 to 99150 if any of these codes is performed on the same day with a medical/surgical code listed in Appendix G of CPT and the service is provided to a patient in a facility.	X			X							
5618.5.1	Contractors shall review claims data for codes 99148 to 99150 and determine whether a pre or post payment review of claims is needed. This review is required to ensure that the conscious sedation code 99148 to 99150 is performed on the same day with a medical/surgical code listed in Appendix G of CPT.	X			X							
5618.6	Contractors shall adjust claims brought to their attention that were not processed in accordance with the Medicare physician fee schedule data base indicators assigned to the conscious sedation codes.	X			X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5618.7	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 1 week of the availability of the provider education article. In addition, the	x			x							

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	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.											

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

B. For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): For policy issues, contact Jim Menas (410)-786-4507; James.Menas@cms.hhs.gov. For operational issues, contact Mel Page-Lasowski (410)-786-4727; Melvia.pagelasowski@cms.hhs.gov

Post-Implementation Contact(s): Regional Office Staff

VI. FUNDING

A. No additional funding will be provided by CMS; carrier activities are to be carried out within their FY 2007 operating budgets.

B. The MAC contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). 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.

50 - Payment for Anesthesiology Services

(Rev. 1324; Issued: 08-27-07; Effective: 01-01-06; Implementation: 10-01-07)

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 carriers by means of the HCPCS file released annually. The public can access the base units on the CMS homepage through the anesthesiologists 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

Carriers 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 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

Carriers determine 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.

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

Carriers 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, carriers compute time units by dividing reported anesthesia time by 15 minutes. Round the time unit to one decimal place. Carriers do 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

Carriers pay 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.

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

Carriers 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. Carriers 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.

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.