CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3747	**Date: April 14, 2017**
	Change Request 10001

SUBJECT: Payment for Moderate Sedation Services

I. SUMMARY OF CHANGES: This CR clarifies existing manual language to bring the manual in line with current payment policy for moderate sedation and anesthesia services.

EFFECTIVE DATE: January 1, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 15, 2017

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	12/50/Payment for Anesthesiology Services
R	12/140.1/Qualified Nonphysician Anesthetists
R	12/140.2/Entity or Individual to Whom Fee Schedule is Payable for Qualified Nonphysician Anesthetists
R	12/140.3/Anesthesia Fee Schedule Payment for Qualified Nonphysician Anesthetists
R	12/140.3.1/Conversion Factors Used for Qualified Nonphysician Anesthetists
R	12/140.3.2/Anesthesia Time and Calculation of Anesthesia Time Units
R	12/140.3.3/Billing Modifiers
R	12/140.3.4/General Billing Instructions
R	12/140.4.1/An Anesthesiologist and Qualified Nonphysician Anesthetist Work Together
R	12/140.4.2/Qualified Nonphysician Anesthetist and an Anesthesiologist in a Single Anesthesia Procedure
R	12/140.4.3/Payment for Medical or Surgical Services Furnished by CRNAs
R	12/140.5/Payment for Anesthesia Services Furnished by a Teaching CRNA

III. FUNDING:

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3747	Date: April 14, 2017	Change Request: 10001

SUBJECT: Payment for Moderate Sedation Services

EFFECTIVE DATE: January 1, 2017
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 15, 2017

I. GENERAL INFORMATION

A. Background: The purpose of this CR is to clarify existing manual language to bring the manual in line with current payment policy for moderate sedation and anesthesia services.

B. Policy: This revision represents a change in policy for payment of moderate sedation services furnished in conjunction with and in support of certain procedural services.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
10001.1	Contractors shall note the changes to Pub. 100-04, Medicare Claims Processing Manual, Chapter 12, Sections 50 and 140.	X	X							
10001.2	Contractors need not search their files to either retract payment for claims already paid or to retroactively pay claims. However, contractors shall adjust claims brought to their attention.	X	X							

I. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
10001.3	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/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 sites and include information about it in a listserv message within 5 business days after receipt of the notification from CMS announcing the availability of the article. In addition, the provider education article shall be included in the contractor's 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: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Jamie Hermansen, 410-786-2064 or jamie.hermansen@cms.hhs.gov , Gail Addis, 410-786-4522 or gail.addis@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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.

ATTACHMENTS: 0

50 - Payment for Anesthesiology Services

(Rev. 3747; Issued: 04-14-17; Effective: 01-01-17; Implementation: 05-15-17)

A. General Payment Rule

The fee schedule amount for physician anesthesia services furnished 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 A/B MACs by means of the HCPCS file released annually. CMS releases the conversion factor annually. The base units *and conversion factor are available on the CMS website at: https://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center.html.*

B. Payment at Personally Performed Rate

The A/B MAC 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;
- 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 *that meets the requirements for payment at the medically directed rate*. The physician meets the teaching physician criteria in §100.1.4;
- The physician is continuously involved in a single case involving a student nurse anesthetist;
- If the physician is involved with a single case with a *qualified nonphysician anesthetist (a certified registered nurse anesthetist (CRNA) or an anesthesiologist's assistant))*, A/B MACs may pay the physician service and the *qualified nonphysician anesthetist* service in accordance with the *requirements for payment at the medically directed rate;*

  Or

- The physician and the CRNA (or *anesthesiologist's assistant*) 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.

C. Payment at the Medically Directed Rate

The A/B MAC determines payment *at the medically directed rate* for the physician on the basis of 50 percent of the allowance for the service performed by the physician alone. *Payment will be made at the medically directed rate* if the physician medically directs qualified individuals *(all of whom could be CRNAs, anesthesiologists' assistants, interns, residents, or combinations of these 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, *if applicable,* induction and emergence;

- Ensures that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified *individual*;

- 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.

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 *in the anesthesia plan,* including induction and emergence, where indicated.

NOTE: Concurrency refers to 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 *medically* directs three concurrent procedures, two of which involve non-Medicare patients and the remaining a Medicare patient, this represents three concurrent cases.

The requirements for payment at the medically directed rate also apply to cases involving student nurse anesthetists if the physician medically directs two concurrent cases, *with* each *of the two cases involving* a student nurse anesthetist, or the physician directs one case involving a student nurse anesthetist and another involving a *qualified individual (for example:* CRNA, *anesthesiologist's assistant*, intern or resident*)*.

The requirements for payment at the medically directed rate do not apply to a single resident case that is concurrent to another anesthesia case paid *at the medically directed rate* 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 *furnishing services that meet the requirements for payment at the medically directed rate* 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, periodic (rather than continuous) monitoring of an obstetrical patient*, receiving patients entering the operating suite for the next surgery, checking or discharging patients in the recovery room, or handling scheduling matters,* do not substantially diminish the scope of control exercised by the physician *and do not constitute a separate service for the purpose of determining whether the requirements for payment at the medically directed rate are met.*

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 *would not meet the requirements for payment at the medically directed rate.* A/B MACs may not make payment under the fee schedule.

D. Payment at Medically Supervised Rate

The A/B MAC 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* 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, 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, 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 code 01996 *(daily hospital management of epidural or subarachnoid continuous drug administration)*.

For purposes of this section, anesthesia practitioner means:

- a physician who performs the anesthesia service alone,
- a CRNA who is *furnishing services that do not meet the requirements for payment at the* medically directed *rate*,
- a *qualified nonphysician anesthetist* who is *furnishing services that meet the requirements for payment at the* medically directed *rate*.

The physician who medically directs the *qualified nonphysician anesthetist* would ordinarily report the same time as the *qualified nonphysician anesthetist* reports for the service.

H. Monitored Anesthesia Care

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.

The A/B MAC pays for reasonable and medically necessary monitored anesthesia care services on the same basis as other anesthesia services. *If* the physician personally performs the monitored anesthesia care case*, payment is made under the fee schedule using the payment rules for payment at the personally performed rate. If* the physician medically directs four or fewer concurrent cases and monitored anesthesia care represents one or more of these concurrent cases*, payment is made under the fee schedule using the payment rules for payment at the medically directed rate*. Anesthesiologists use *the QS* modifier to report monitored anesthesia care cases*, in addition to reporting the actual anesthesia time and one of the payment modifiers on the claim.*

I. Anesthesia Claims Modifiers

Physicians report the appropriate modifier to denote whether the service *meets the requirements for payment at the* personally performed *rate,* medically directed *rate*, or medically supervised *rate*.

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

NOTE: The QS modifier can be used by a physician or a qualified nonphysician anesthetist and is for informational purposes. Providers must report actual anesthesia time and one of the payment modifiers on the claim.

QY - Medical direction of one *qualified nonphysician* anesthetist by an anesthesiologist

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

NOTE: 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 *of this chapter*. One of the payment modifiers must be used in conjunction with the GC modifier.

The A/B MAC 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 *meets the requirements for payment at the* medically directed *rate.* They must also be able to determine the number of anesthesia time units from actual anesthesia time reported on the claim. The A/B MAC must multiply allowable units by the anesthesia-specific conversion factor used to determine fee schedule payment for the payment area.

J. Moderate Sedation Services Furnished in Conjunction with and in Support of Procedural Services

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. 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.

Practitioners will report the appropriate CPT and/or HCPCS code that describes the moderate sedation services furnished during a patient encounter, which are furnished in conjunction with and in support of a procedural service, consistent with CPT guidance.

Refer to §50 and §140 of this chapter for information regarding reporting of anesthesia services furnished in conjunction with and in support of procedural services.

K. Anesthesia for Diagnostic or Therapeutic Nerve Blocks and Services Lower in Intensity than Moderate Sedation

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 *the appropriate* CPT code *consistent with CPT guidance*. The service must meet the criteria for monitored anesthesia care *as described in this section.* 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 and the injection or block. However, the anesthesia service must meet the requirements for *moderate* sedation and if a lower level complexity anesthesia service is provided, then the *moderate* 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 sedation, such as a local or topical anesthesia, then the *moderate* sedation code should not be reported and no *separate* payment should be allowed by the *A/B* MAC.

140.1- Qualified Nonphysician Anesthetists

(Rev. 3747; Issued: 04-14-17; Effective: 01-01-17; Implementation: 05-15-17)

For payment purposes, the term *"*qualified nonphysician anesthetist*" is* used to refer to both *certified registered nurse anesthetists (*CRNAs*)* and *anesthesiologists' assistants* unless *otherwise separately discussed.*

An *anesthesiologist's assistant means* a person who:

- *Works under the direction of an anesthesiologist;*
- *Is in compliance with all applicable requirements of State law, including any licensure requirements the state imposes on nonphysician anesthetists; and*
- *Is a graduate of a medical school based anesthesiologist assistant educational program that –*
    - *Is accredited by the Committee on Allied Health Education and Accreditation;*

      And
    - *Includes approximately two years of specialized basic science and clinical education in anesthesia at a level that builds on a premedical undergraduate science background.*

A CRNA is a registered nurse who*:*

- is licensed *as a registered professional nurse* by the State in which the nurse practices;
- *Meets any licensure requirements the State imposes with respect to nonphysician anesthetists;*
- *Has graduated from a nurse anesthesia educational program that meets the standards of the Council on Accreditation of Nurse Anesthesia Programs; and*
- *Meets the following criteria:*
    - *Has passed a certification examination of the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists;*

      Or
    - *Is a graduate of a nurse anesthesia educational program that meets the standards of the Council of Accreditation of Nurse Anesthesia Educational Programs, and within 24 months of graduation, has passed a certification examination of the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists.*

140.2- Entity or Individual to Whom Fee Schedule is Payable for Qualified Nonphysician Anesthetists

(Rev. 3747; Issued: 04-14-17; Effective: 01-01-17; Implementation: 05-15-17)

Payment for the services of a qualified nonphysician anesthetist may be made *directly* to the qualified nonphysician anesthetist who furnished the anesthesia services or to a hospital, physician, group practice, or ASC with which the qualified nonphysician anesthetist has an employment or contractual relationship.

140.3- Anesthesia Fee Schedule Payment for Qualified Nonphysician Anesthetists

(Rev. 3747; Issued: 04-14-17; Effective: 01-01-17; Implementation: 05-15-17)

Payment for the services *furnished by* qualified nonphysician *anesthetists are subject to the usual Part B coinsurance and deductible, and are made* only on an assignment basis. The assignment agreed to by the qualified nonphysician anesthetist is binding upon any other person or entity claiming payment for the service. Except for deductible and coinsurance amounts, any person who knowingly and willfully presents or causes to be presented to a Medicare beneficiary a bill or request for payment for services of a qualified nonphysician anesthetist for which payment may be made on an assignment-related basis is subject to civil monetary penalties.

The fee schedule for anesthesia services furnished by qualified nonphysician anesthetists is the least of 80 percent of:

- The actual charge;
- The applicable locality anesthesia conversion factor multiplied by the sum of allowable base and time units.

140.3.1- Conversion Factors Used for Qualified Nonphysician Anesthetists

(Rev. 3747; Issued: 04-14-17; Effective: 01-01-17; Implementation: 05-15-17)

The conversion factors applicable to anesthesia services are increased by the update factor used to update physicians' services under the physician fee schedule. They are *generally* published in November of the year preceding the year in which they apply.

140.3.2- Anesthesia Time and Calculation of Anesthesia Time Units

(Rev. 3747; Issued: 04-14-17; Effective: 01-01-17; Implementation: 05-15-17)

Anesthesia time means the time during which a qualified nonphysician anesthetist is present with the patient. It starts when the qualified nonphysician anesthetist begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ends when the qualified nonphysician anesthetist 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, the qualified nonphysician anesthetist can add blocks of time around an interruption in anesthesia time as long as the qualified nonphysician anesthetist is furnishing continuous anesthesia care within the time periods around the interruption.

140.3.3- Billing Modifiers

((Rev. 3747; Issued: 04-14-17; Effective: 01-01-17; Implementation: 05-15-17)

The following modifiers are used *by qualified nonphysician anesthetists* when billing for anesthesia services:

- QX – Qualified nonphysician anesthetist *service: With* medical direction by a physician.
- QZ – CRNA *service: Without* medical direction by a physician.
- QS – Monitored *anesthesia* care services

  NOTE: The QS modifier can be used by a physician or a qualified nonphysician anesthetist and is for informational purposes. Providers must report actual anesthesia time and one of the payment modifiers on the claim.

140.3.4 - General Billing Instructions

(Rev. 3747; Issued: 04-14-17; Effective: 01-01-17; Implementation: 05-15-17)Claims for reimbursement for qualified nonphysician anesthetist services should be completed in *accordance* with existing billing instructions for anesthesiologists with the following additions.

- If an employer-physician furnishes concurrent medical direction for a procedure involving CRNAs and the medical direction service is unassigned, the physician should bill on an assigned basis on a separate claim for the qualified nonphysician anesthetist service. If the physician is participating or takes assignment, both services should be billed on one claim but as separate line items.

- All claims forms must have the provider billing number of the *qualified nonphysician anesthetist* and/or the employer of the qualified nonphysician anesthetist performing the service in either block 24.H of the Form CMS-1500 and/or block 31 as applicable. Verify that the billing number is valid before making payment.

Payments should be calculated in accordance with Medicare payment rules in §140.3. *The* A/B MAC must institute all necessary payment edits to assure that duplicate payments are not made to physicians for *qualified nonphysician anesthetist* services or to a *qualified nonphysician anesthetist* directly for bills submitted on their behalf by qualified billers.

A CRNA is identified on the provider file by specialty code 43. *An anesthesiologist's assistant is* identified on the provider file by specialty code 32.

140.4 – Qualified Nonphysician Anesthetist Special Billing and Payment Situations

(Rev. 3747; Issued: 04-14-17; Effective: 01-01-17; Implementation: 05-15-17)

140.4.1 - An Anesthesiologist and Qualified Nonphysician Anesthetist Work Together

(Rev. 3747; Issued: 04-14-17; Effective: 01-01-17; Implementation: 05-15-17)*A/B MACs* will distribute educational releases and use other established means to ensure that anesthesiologists understand the requirements for medical direction of qualified nonphysician anesthetists.

A/B MACs will perform reviews of payments for anesthesiology services to identify situations in which an excessive number of concurrent anesthesiology services may have been performed. They will use peer practice and their experience in developing review criteria. They will also periodically review a sample of claims for medical direction of four or fewer concurrent anesthesia procedures. During this process physicians may be requested to submit documentation of the names of procedures performed and the names of the anesthetists *medically* directed.

Physicians who cannot supply the necessary documentation for the sample claims must submit documentation with all subsequent claims before payment will be made.

140.4.2 - Qualified Nonphysician Anesthetist and an Anesthesiologist in a Single Anesthesia Procedure

(Rev. 3747; Issued: 04-14-17; Effective: 01-01-17; Implementation: 05-15-17)Where a single anesthesia procedure involves both a physician medical direction service and the service of the medically directed qualified nonphysician anesthetist, the payment amount for the service of each is 50 percent of the allowance otherwise recognized had the service been furnished by the anesthesiologist alone. *For the single medically directed service, the* physician will use the *QY modifier* and the qualified nonphysician anesthetist will use the *QX modifier.*

In unusual circumstances when it is medically necessary for both the CRNA and the anesthesiologist to be completely and fully involved during a procedure, full payment for the services of each provider is allowed. The physician would report using the AA modifier and the CRNA *would report using the* QZ modifier. Documentation must be submitted by each provider to support payment of the full fee.

140.4.3 - Payment for Medical or Surgical Services Furnished by CRNAs

(Rev. 3747; Issued: 04-14-17; Effective: 01-01-17; Implementation: 05-15-17)

Payment shall be made for reasonable and necessary medical or surgical services furnished by CRNAs if they are legally authorized to perform these services in the *State* in which *the* services are furnished. Payment is determined under the physician fee schedule on the basis of the national physician fee schedule conversion factor, the geographic adjustment factor, and the resource-based relative value units for the medical or surgical service.

140.5 - Payment for Anesthesia Services Furnished by a Teaching CRNA

(Rev. 3747; Issued: 04-14-17; Effective: 01-01-17; Implementation: 05-15-17)

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 QZ modifier. No payment is made under Part B for the service provided by a student nurse anesthetist.

The A/B MAC may allow payment, as follows, if a teaching CRNA is involved *in cases* with two student nurse anesthetists:

- 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 9:45a.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.

The teaching CRNA (not under the medical direction of a physician), can be paid for his *or* her involvement in each of two concurrent cases with student nurse anesthetists; *allow* payment at the regular fee schedule rate. The *teaching* CRNA reports the anesthesia service using the QZ modifier.

To bill the anesthesia base units, the *teaching* CRNA must be present with the student nurse anesthetist during pre and post anesthesia care for each of the two cases. To bill anesthesia time for each case, the teaching CRNA must continue to devote his *or* 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 *cases*, the experience and skills of the student nurse *anesthetists, and* the *patients'* health status and other factors. The teaching CRNA must document his *or* her involvement in the cases with the student nurse anesthetists.