Marketplace Anesthesia Guidelines and Modifiers

Anesthesia modifiers are added to the applicable procedure code to indicate the specific anesthesia service or who performed the service. Modifiers identifying who performed the anesthesia service **must** be billed in the primary modifier field to receive appropriate reimbursement. Additional or reduced payment for modifiers is based on CMS requirements, as applicable.

All this information was taken From the CMS – Medicare Claims Processing Manual, Chapter 12 – Physicians/Non-physician Practitioners:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

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).

Example:

Billed minutes 148/15 minutes = 9.866666666 (9.9 to the nearest one decimal)
3 (base unit based on billed CMS code) + 9.9 = 12.9
*12.9 * 100(conversion factor) = $1290*

Utilizing the AHCA Anesthesia Coverage and Limitations Handbook, Centers for Medicare & Medicaid Services (CMS) and American Society of Anesthesiologist (ASA)guidelines, we updated our Anesthesia Guidelines. In sum, Anesthesiologist and Anesthetist must bill the appropriate modifiers in order to receive proper payment of claims and are required. If not billed, the claim should deny.

Per the CMS - https://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center and within the Medicare Claims Processing Manual (Chapter 12; Physician/Nonphysician Practitioner) it states:

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.

A list of modifiers and definition is explained within the same CMS processing manual.

Furthermore, the CMS Anesthesia Center points to the American Society of Anesthesiologist and the American Association of Nurse Anesthetists which defines the use of modifier and gives the below example:

Dr. A medically directs CRNA A in providing anesthesia care to a patient for removal of her gall bladder. This is one of three concurrent cases.

- ***CPT Code***
  00790 - Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy; not otherwise specified
- ***HCPCS Modifiers***
  *Dr A reports **QK** - Medical Direction of two, three or four concurrent anesthesia procedures involving qualified individuals*
  *CRNA A reports the same CPT code with modifier **QX** - Qualified nonphysician anesthetist service: With medical direction by a physician*

Dr. B personally provides anesthesia care for a patient undergoing a total right knee replacement.

- ***CPT Code***
  01402 - Anesthesia for total knee arthroplasty
- ***HCPCS Modifier***
  ***AA** - Anesthesia Services performed personally by the anesthesiologist*

Anesthesia Modifiers & Descriptions

Anesthesia Modifiers	Description	Reimbursement Percentage
AA	Anesthesia Services performed by the anesthesiologist	100% CMS Language: *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.* *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.*
AD	Medical Supervision by a physician, more than 4 concurrent anesthesia procedures	100%

QK	Medical direction of two, three, four concurrent anesthesia procedures involving qualified individuals	50% CMS Language: *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.*
QX	Qualified non-physician anesthetist services: with medical direction by a physician	*50%* CMS Language: *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.
QY	Medical direction of one qualified non-physician anesthetist by an anesthesiologist	50% Claim Language: *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.*
QZ	CRNA service: Without medical direction by a physician	100% CMS Language: *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.*

		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.
QS	Monitored anesthesia care services. This modifier is for informational purposes.	N/A - informational
22	Increased Procedural Services	N/A - informational
78	Unplanned Return to Operating/Procedure Room by the same physician	N/A - informational
G8	Monitored anesthesia care for deep complex, complicated, or markedly invasive surgical procedures	N/A - informational
G9	Monitored anesthesia care for patient who has a history of severe cardio-pulmonary condition	N/A - informational

Additional Resources

Medicare Claims Processing Manual Chapter 12
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

American Society of Anesthesiology
https://www.asahq.org/quality-and-practice-management/managing-your-practice/timely-topics-in-payment-and-practice-management/anesthesia-payment-basics-series-codes-and-modifiers

If you have questions, please contact Molina Healthcare at: 855-322-4076
Thank you for your continued care to our members!
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