



Anesthesia

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Part B



IMPORTANT



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IMPORTANT



MEDICARE PART B

Anesthesia

Table of Contents

ANESTHESIA SERVICES	1
Modifiers	2
Payment Conditions for Anesthesiology Services.....	3
Definition of Concurrent Medically Directed Anesthesia Procedures.....	5
Medical Supervision.....	6
Group Practice.....	7
Billing Documentation	7
Unusual Circumstances – CRNA and Anesthesiologist.....	7
One Procedure – Two Anesthesiologists or Two CRNAs	7
Teaching Physician.....	7
CRNA Services.....	9
Qualified Anesthetists	9
CRNA Billing.....	10
CRNA Reimbursement	10
CRNA and Anesthesiologist in a Single Anesthesia Procedure.....	10
Payment for Anesthesia Services of Teaching CRNAs	11
ANESTHESIA FORMULA	13
ANESTHESIA TIME.....	14
MEDICARE ANESTHESIA BASE UNITS	16
CONVERSION FACTOR	17
REIMBURSEMENT EXAMPLES	18
Texas Example 1	18
Example 2.....	18
MULTIPLE ANESTHESIA SERVICES	21
Same Operative Session	21
MISCELLANEOUS	22
Blood Gas Monitoring	22
Bundled Services.....	22
Pre-Anesthetic Exams/Cancelled Surgery.....	22
Locum Tenens.....	22
Add-On Codes for Anesthesia	22
MONITORED ANESTHESIA CARE (MAC).....	28
Description.....	28
REVISION HISTORY	31

MEDICARE PART B

Anesthesia

ANESTHESIA SERVICES

Anesthesia is the administration of a drug or gas to induce partial or complete loss of consciousness. Services involving administration of anesthesia should be reported by the use of the Current Procedural Terminology (CPT) anesthesia five-digit procedure code plus modifier codes. Surgery codes are not appropriate unless the anesthesiologist or Certified Registered Nurse Anesthetist (CRNA) is performing the surgical procedure.

An anesthesiologist, CRNA or an Anesthesia Assistant (AA) can provide anesthesia services. The anesthesiologist and the CRNA can bill separately for anesthesia services they personally perform. In cases of medical direction, both the anesthesiologist and the CRNA would bill Medicare for their component of the procedure. Each provider should use the appropriate anesthesia modifier.

Note: If the surgery is non-covered, the anesthesia is also non-covered.

Anesthesia procedure codes are organized as follows:

Descriptor	Code Range
Head	00100–00222
Neck	00300–00352
Thorax (chest wall and shoulder girdle)	00400–00474
Intrathoracic	00500–00580
Spine and Spinal Cord	00600–00670
Upper Abdomen	00700–00797
Lower Abdomen	00800–00882
Perineum	00902–00952
Pelvis (except hip)	01112–01190
Upper Leg (except knee)	01200–01274
Knee and Popliteal Area	01320–01444
Lower Leg (below knee, includes ankle and foot)	01462–01522
Shoulder and Axilla	01610–01682
Upper Arm and Elbow	01710–01782
Forearm, Wrist and Hand	01810–01860
Radiological Procedures	01916–01936
Burn Excisions or Debridement	01951–01953
Obstetric	01958–01969
Other Procedures	01990–01999

MEDICARE PART B

Anesthesia

Modifiers

Modifiers are two-digit indicators used to modify payment of a procedure code, assist in determining appropriate coverage or otherwise identify the detail on the claim. Every anesthesia procedure billed to Medicare **must** include one of the following anesthesia modifiers: AA, QY, QK, AD, QX or QZ. The other modifiers listed below may be used to identify specific situations in addition to the required modifiers.

Example:

An anesthesiologist is personally performing the anesthesia service to the patient and he administered Monitored Anesthesia Care (MAC). The modifiers billed to Medicare would be AA and QS consecutively.

Anesthesiologist

(Do not use the following modifiers if the provider of service is a CRNA or AA.)

Modifier	Description
AA	Anesthesia services personally performed by the anesthesiologist
QY	Medical direction of one CRNA by an anesthesiologist
QK	Medical direction of two, three or four concurrent anesthesia procedures
AD	Supervision, more than four procedures

CRNA

(Do not use the following modifiers if the provider of service is an Anesthesiologist.)

Modifier	Description
QX	Anesthesia, CRNA medically directed
QZ	Anesthesia, CRNA not medically directed

MAC

Modifier	Description
QS	Monitored Anesthesia Care (MAC) services (can be billed by a CRNA, AA or physician)

MEDICARE PART B

Anesthesia

Modifiers should be entered in item 24d following the procedure code on the CMS-1500 claim form or electronic equivalent.

CMS-1500 Example:

24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSON Family Plan		I. ID. QUAL		J. RENDERING PROVIDER ID. #	
MM	DD	YY	MM	DD	YY																	
01	01	xx				21		00100	AA				100	00	40			NPI	XXXXXXXXXX			
																		NPI				

For complete claim form and electronic claim filing instructions, see the CMS-1500 Claim Form and Unprocessable/Rejected Claims Manual:

<http://www.trailblazerhealth.com/Publications/Training Manual/claim form instructions.pdf>

Payment Conditions for Anesthesiology Services

Personally Performed Services

- The physician personally performed the entire anesthesia service alone.
- The physician is involved with one anesthesia case with a resident and the physician is a teaching physician as defined in the IOM, Pub.100-04, Chapter 12, Section 100 at <http://www.cms.gov/manuals/downloads/clm104c12.pdf>.
- 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 Section 100.1.4 of the IOM (see link above) and the service is provided on or after January 1, 2010.
- The physician is continuously involved in a single case involving a student nurse anesthetist.
- 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 modifier AA and the CRNA reports modifier QZ for a non-medically directed case.

Medical Direction

For a single anesthesia case involving both a physician medical direction service and the service of the medically directed CRNA, the payment amount for each service may be no greater than 50 percent of the allowance. The total payment for both may not exceed the amount that would be paid had the service been furnished solely by the anesthesiologist.

Anesthesia

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 only in the most demanding procedures of the anesthesia plan, including, if applicable, induction and emergence.
- Ensures that any procedures in the anesthesia plan that he 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.
- Provides indicated post-anesthesia care.

Note: For medical direction, the physician must document in the medical record that he performed the pre-anesthetic exam and evaluation, provided indicated post-anesthesia care, was present during some portion of the anesthesia monitoring, and was present during the most demanding procedures, including induction and emergence, where indicated.

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 two concurrent anesthesia cases involving residents.

Two separate claims must be filed for medically directed anesthesia procedures—one for the anesthesiologist and one for the CRNA. Medical direction can occur in several different scenarios. When billing for the anesthesia services, please refer to the following examples for appropriate modifier usage:

- An anesthesiologist is medically directing one CRNA. The anesthesiologist should bill with the QY modifier and the CRNA should bill with the QX modifier. The Medicare payment would be split equally between the two providers with each provider receiving 50 percent of the Medicare allowable amount for the procedure.
- An anesthesiologist is medically directing two, three or four CRNAs. The anesthesiologist should bill with the QK modifier and the CRNA should bill with

MEDICARE PART B

Anesthesia

the QX modifier. The Medicare payment would be split equally between the two providers with each provider receiving 50 percent of the Medicare allowable amount for the procedure.

If the medical direction requirements are not met, a CRNA may submit a claim with the QZ modifier indicating the service was without medical direction by a physician.

Definition of Concurrent Medically Directed Anesthesia Procedures

Concurrency is defined with regard to the maximum number of procedures the anesthesiologist 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 is a Medicare patient, this represents three concurrent procedures. The following example illustrates this concept and guides anesthesiologists in determining how many procedures they are directing.

Example: Procedures A through E are medically directed procedures involving CRNAs. The starting and ending times for each procedure represent the periods during which “anesthesia time” is counted.

Procedure A	Begins at 8 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 a.m. and lasts until noon.
Procedure E	Begins at 9:10 a.m. and lasts until 9:55 a.m.

Procedure	Number of Concurrent Medically Directed Procedures
A	2
B	2
C	3
D	3
E	3

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

From 8:10–8:45 a.m., the length of procedure B, the anesthesiologist medically directed two concurrent procedures. From 8:10–8:20 a.m., the anesthesiologist medically directed procedures A and B; from 8:20–8:30 a.m., the anesthesiologist medically

Anesthesia

directed only procedure B; from 8:30–8:45 a.m., the anesthesiologist medically directed procedures B and C. Thus, during procedure B, the anesthesiologist medically directed two concurrent procedures.

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

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

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 Medicare 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 and not reimbursed by Medicare.

Medical Supervision

If an anesthesiologist is medically directing more than four CRNAs, the Medicare regulations indicate that the service must be billed as medically supervised as opposed to medically directed anesthesia services. The anesthesiologist should bill with the AD modifier and the CRNA should bill with the QX modifier. The Medicare payment to the CRNA would be 50 percent of the Medicare allowable amount for the procedure. Payment to the anesthesiologist will be based on 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 procedure. An additional time unit can be recognized if the physician can document he was present at induction.

Anesthesia

Group Practice

If anesthesiologists are in a group practice, one physician member may provide the pre-anesthesia examination and evaluation while another fulfills the other criteria. Also, 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 physicians furnished the services and identify the physicians who rendered them.

Billing Documentation

Periodically, physicians will be required to submit documentation showing the names of the anesthetists directed and procedures performed for selected claims. If a physician is unable to supply the necessary documentation for the sample claims, he may be referred for pre-payment or post-payment auditing.

Unusual Circumstances – CRNA and Anesthesiologist

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. Each provider must submit documentation to support payment of the full fee. The physician would use the AA modifier and the CRNA would use QZ or the modifier for a non-medically directed case. Documentation must be submitted by each provider to support payment of the full fee.

One Procedure – Two Anesthesiologists or Two CRNAs

When the first anesthesiologist or the first CRNA starts an anesthesia procedure and he has to leave the patient to start another anesthesia procedure, and the procedure is then taken over by a second anesthesiologist or a second CRNA who then finishes the procedure, a claim should be submitted for the anesthesiologist or CRNA who spent the longest length of time with the patient. The amount of time reported on the Medicare claim should be the combined total time period of the procedure. Documentation should include the time spent with the patient for both the first and second anesthesiologist or CRNA.

Example:

- The first anesthesiologist or CRNA spent 15 minutes with the patient.
- The second anesthesiologist or CRNA spent 45 minutes with the patient.
- The claim would be submitted for the second anesthesiologist or CRNA with 60 minutes for the entire time period of the procedure.

Teaching Physician

Medicare pays an unreduced fee schedule payment if a teaching anesthesiologist is involved in a single procedure with one resident. The teaching physician must document in the medical records that he was present during all critical or key portions of the

MEDICARE PART B

Anesthesia

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 non-physician 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 is present with the resident. The anesthesiologist can bill base units if he is present with the resident throughout pre- and post-anesthesia care. The anesthesiologist should use the AA modifier to report such cases. The teaching anesthesiologist must document his 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 National Provider Identifier (NPI) of the teaching anesthesiologist who started the case must be indicated in the appropriate field on the claim form or electronic equivalent.

The teaching anesthesiologist should use the AA modifier and the GC certification modifier to report such cases.

Modifier

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

Examples:

If the teaching physician is involved in a single anesthesia procedure with one resident, the teaching physician should bill his services with the AA and GC modifiers.

If the teaching physician is involved in two concurrent anesthesia cases with two 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 is present with residents. The teaching physician should bill the services to Medicare for his services with the AA and GC modifiers.

When filing claims to Medicare, the teaching physician should use the anesthesia modifier first (the payment modifier), followed by the GC modifier. By submitting the GC modifier, the teaching anesthesiologist is indicating he has been present during all critical or key portions of a single anesthesia procedure or concurrent anesthesia procedure.

CRNA Services

Medicare provides payment to CRNAs and AAs. CRNAs and AAs may bill directly for their services or have payment made to an employer or an entity under which they have a contract. This could be a hospital, physician, group practice or Ambulatory Surgical Center (ASC).

Reimbursement for CRNA services is made only on an assignment basis.

Qualified Anesthetists

For payment purposes, CRNAs include both qualified anesthetists and AAs. An AA is a person who:

- Is permitted by state law to administer anesthesia and who has successfully completed a six-year program for AAs of which two years consist of specialized academic and clinical training in anesthesia.

A CRNA is a registered nurse who is licensed by the state in which the nurse practices and who:

- Is currently certified by the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists.
- Or,
- Has graduated within the past 18 months from a nurse anesthesia program that meets the standards of the Council of Accreditation of Nurse Anesthesia Educational Programs and is awaiting initial certification.

MEDICARE PART B

Anesthesia

CRNA Billing

All claims for anesthesia furnished by qualified anesthetists must indicate:

- The duration of the procedure in minutes – how much time elapsed from the preparation of the patient for induction to the moment when the anesthetist was no longer in attendance.
- Whether an anesthesiologist or other physician (except the surgeon) functioning as an anesthesiologist medically directed the anesthesia. Use the QX or QZ modifier to fulfill this requirement.

QX	Anesthesia; CRNA medically directed
QZ	Anesthesia; CRNA not medically directed
QS	Monitored Anesthesia Care (MAC) services (can be billed by a CRNA or a physician)

Anesthesiologists should submit their services for medical direction on a separate claim from the services of the CRNA.

CRNA Reimbursement

Payment can be made for medical or surgical services furnished by non-medically directed qualified anesthetists if they are allowed to furnish these services under state law. These services may include the insertion of the Swan-Ganz catheters, central venous pressure lines, intra-arterial lines, pain management, emergency intubation and the pre-anesthetic examination and evaluation of a patient who does not undergo surgery. 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.

Anesthesia services are assigned the same base units for physician anesthesia services using the uniform relative value guide.

Reimbursement is made on an assignment basis only.

Services furnished by qualified anesthetists are subject to the Part B deductible and coinsurance. If the Part B deductible has been satisfied, payment is based on 80 percent of the actual charge or 80 percent of the allowable amount utilizing the anesthesia calculation, whichever is less.

CRNA and Anesthesiologist in a Single Anesthesia Procedure

When a single anesthesia procedure involves both a physician medical direction service and the service of the medically directed CRNA, 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. The CRNA should use the QX modifier. For the

MEDICARE PART B

Anesthesia

single medically directed service, the physician should use the modifier QY.

Payment for Anesthesia Services of Teaching CRNAs

A teaching CRNA who is not under the medical direction of a physician can be paid under Medicare Part B when continuously present and supervising a single case involving a student nurse anesthetist. In this single-case scenario, if the teaching CRNA is supervising a case performed by a student nurse anesthetist and is present with the student throughout the case, payment is made at the regular fee schedule rate. The CRNA should report the service using the usual QZ modifier, which designates that he is not medically directed by an anesthesiologist.

The American Association of Nurse Anesthetists (AANA) indicates that its standards for approved nurse anesthetist training programs allow a teaching CRNA to supervise two concurrent cases involving student nurse anesthetists. A teaching CRNA who is not under the medical direction of a physician can be paid under Medicare Part B when supervising two student nurse anesthetists. Prior to January 1, 2010, in this scenario, the CRNA has been paid in the following manner:

- By recognizing the full base units (assigned to the anesthesia code) when the teaching CRNA is present with the student nurse anesthetist throughout pre- and post-anesthesia care.
- By recognizing the actual time the teaching CRNA is personally present with the student nurse anesthetist.

Example:

A teaching CRNA is involved in two concurrent cases with student nurse anesthetists.

Case #	Actual Time	Description	CRNA May Report
Case 1	9–11 a.m.	The teaching CRNA is present in Case 1 from 9–9:30 a.m. and from 10:15–10:30 a.m.	45 minutes of Anesthesia time (3 time units)
Case 2	9:45–11:30 a.m.	The teaching CRNA is present in Case 2 from 9:45–10:14 a.m. and from 10:31–11:30 a.m.	88 minutes of Anesthesia time (5.9 time units)

Change Request (CR) 6706 provides that 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, when involved with two concurrent cases with student nurse anesthetists (on or after this date), he can be paid at the regular fee schedule rate for each case.

To bill the base units for each of the two cases, the teaching CRNA must be present with the student during the pre- and post-anesthesia care for each case.

Anesthesia

In addition, while he can decide how to allocate 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 CRNA must continue to devote all of his time to the two concurrent student nurse anesthetist cases and not be involved in other anesthesia cases. The teaching CRNA may bill usual anesthesia time for each anesthesia case.

For services furnished on or after January 1, 2010, the teaching CRNA should report these cases with the QZ modifier as described above. The teaching CRNA's medical record documentation in these cases must be sufficient to support the payment of the fee and be available for review upon request. Additionally, be aware that no payment is made under Part B for the service provided by a student nurse anesthetist.

Additional Information:

More information regarding payment for teaching anesthesiologists and CRNAs can be found in CR 6706 located at:

<http://www.cms.gov/Transmittals/downloads/R1859CP.pdf>

The CMS MLN Matters® article is located at:

<http://www.cms.gov/MLN MattersArticles/downloads/MM6706.pdf>

Anesthesia

ANESTHESIA FORMULA

The allowance for anesthesia services is based on the following formula:

$$\text{(Time Units + Base Units) X Conversion Factor = Allowance}$$

Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service. In counting anesthesia time, 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.

One time unit will be allowed for each 15-minute interval, or fraction thereof, starting from the time the physician begins to prepare the patient for induction and ending when the patient may safely be placed under post-operative supervision and the physician is no longer in personal attendance. Actual time units will be paid; do not round.

The participation status of the physician furnishing the medical direction will determine the conversion factor used to determine the physician's allowance. **The participating physician conversion factor is always used to determine the allowance for the anesthesia service furnished by the CRNA.** The conversion factor will be for the locality of the performing provider (e.g., physician or CRNA).

When all anesthesia practitioners involved in a procedure are associated in the same group, one practitioner may provide the pre-anesthesia exam and the other practitioner can perform the medical direction and post-anesthesia care. Medical records must indicate the name of the doctor who performed the specific service.

Anesthesia

ANESTHESIA TIME

Anesthesia time begins when the anesthesiologist starts to prepare the patient for the procedure. Normally, this service takes place in the operating room, but in some cases, preparation may begin in another location (i.e., holding area). Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service. In counting anesthesia time, 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.

The following calculations are used when processing claims for anesthesia services:

1. The 15-minute time interval will be divided into the total time indicated on the claim. Total time should always be accurately reported in minutes. Actual time units will be paid; no rounding will be done up to the next whole number – only round to the next tenth.

Example:

$$\begin{aligned} 95 \text{ MINUTES} \div 15 &= 6.33 = 6.3 \\ 79 \text{ MINUTES} \div 15 &= 5.26 = 5.3 \end{aligned}$$

2. The total units derived from Step 1 will constitute total units for time.
3. The time units will be added to the relative value units (base units) assigned to the anesthesia procedure code.
4. Total units derived from Steps 1–3 will then be multiplied by the conversion factor. The final step will result in the calculation amount compared to the billed charge.

Medicare will make payment based on 80 percent of the lesser of the two amounts, subject to the application of the yearly deductible.

The anesthesia relative value (base unit), actual anesthesia time and appropriate conversion factor will be utilized for payments of anesthesia services.

Anesthesiologists and CRNAs must report anesthesia time in total minutes in Item 24G of the CMS-1500 claim form or the electronic equivalent. Complete all other items as required according to the CMS-1500 claim form instructions.

MEDICARE PART B

Anesthesia

CMS-1500 Example:

If total time for anesthesia is one hour, enter 60 minutes in Item 24G.

24.	A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
	From	To			(Explain Unusual Circumstances)				CPT/HCPCS	MODIFIER							
MM	DD	YY	MM	DD	YY												
01	01	XX				21		00100	AA			100 00	60			NPI	XXXXXXXXXX
																NPI	

For complete claim form and electronic claim filing instructions see the CMS-1500 Claim Form and Unprocessable/Rejected Claims Manual:

<http://www.trailblazerhealth.com/Publications/Training Manual/claim form instructions.pdf>

Anesthesia

MEDICARE ANESTHESIA BASE UNITS

Anesthesia base unit values have been assigned to each anesthesia procedure code and reflect the difficulty of the anesthesia services, including the usual pre-operative and post-operative care and evaluation. The base unit is used to determine a portion of the reimbursement amount of the anesthesia procedure.

Note: Base units are automatically calculated and should not be reported on the claim form.

The anesthesia base units can be found at:

<http://www.cms.gov/center/anesth.asp>

Anesthesia

CONVERSION FACTOR

The anesthesia conversion factors for each calendar year are listed by payment locality and are effective for the date the service was provided. The participating physician anesthesia conversion factor is listed first, the non-participating physician anesthesia conversion factor is second, and the non-medically directed conversion factor is listed in the third column.

The non-participating physician conversion factor is computed at 95 percent of the participating physician conversion factor. The limitation in the statute requires that CRNA services not exceed the conversion factor for physicians' anesthesia services.

The anesthesia conversion factors can be found at:

<http://www.trailblazerhealth.com/Payment/Fee Schedules/Anesthesia.aspx>

MEDICARE PART B

Anesthesia

REIMBURSEMENT EXAMPLES

(Time Units + Base Units) x Conversion Factor = Allowance

Texas Example 1

(This is an example only. Providers should check their current anesthesia conversion factors for correct fee amounts.)

Code: 00830
Time: 120 minutes
Locality: Rest of state (participating physician)

Time: $\frac{120}{15} = 8$ units
Code: 00830 = $\frac{4 \text{ units}}{12 \text{ units}}$

Conversion factor \$19.84

Total units = 12 x \$19.84 = \$238.08

The physician's allowed amount would be \$238.08. The physician reimbursement is calculated at 80 percent of the allowed amount.

Example 2

Code: 00830
Time: 120 minutes
Locality: Rest of state (non-par physician and medically directed CRNA)

Time: $\frac{120}{15} = 8$ units
Code: 00830 = $\frac{4 \text{ units}}{12 \text{ units}}$

Conversion factor \$18.85 (non-participating)

Conversion factor \$18.85 @ 50% = \$9.425

Total units = 12 x \$9.425 = \$113.10

Conversion factor \$19.84 (CRNA)

Conversion factor \$19.84 @ 50% = \$9.92

Total units = 12 x \$9.92 = \$119.04

MEDICARE PART B

Anesthesia

In this case, the non-par physician's allowable would be \$113.10, but the CRNA would receive the par physician allowable for locality rest of state, which would be \$119.04. The reimbursement would be 80 percent of the allowed amount.

Use of 9-digit ZIP Codes for Determining the Correct Payment Locality for Services Paid Under the Medicare Physician Fee Schedule (MPFS) and Anesthesia Services.
Effective for Date of Service October 1, 2007.

To view the entire MLN Matters articles (MM 5208 and MM 5730) titled "Use of 9-digit ZIP Codes for Determining the Correct Payment Locality for Services Paid Under the Medicare Physician Fee Schedule (MPFS) and Anesthesia Services," and "Revisions to 9-Digit ZIP Code List Provided in Change Request (CR) 5208," access:

MM 5208:

<http://www.cms.gov/MLNMattersArticles/downloads/MM5208.pdf>

MM 5730 Revisions:

<http://www.cms.gov/MLNMattersArticles/downloads/MM5730.pdf>

Medicare carriers have been directed to determine payment locality for services paid under the MPFS and anesthesia services by using the ZIP code on the claim of where the service was performed. Some ZIP codes fall into more than one payment locality. The CMS ZIP code file uses the convention of the United States Postal Service (USPS) which assigns these ZIP codes into dominant countries. The service may actually be rendered in one county but per the ZIP code, it is assigned into a different county. This causes a payment issue when each of the counties has a different payment locality and therefore a different payment amount.

Effective for dates of service on or after October 1, 2007, CMS will require the submission of nine-digit ZIP codes to carriers for services paid under the MPFS and anesthesia services only when the services are provided in those ZIP code areas with which there is a problem. Claims for services payable under the MPFS and anesthesia services that are NOT performed in one of the ZIP code areas that cross localities may continue to be submitted with five-digit ZIP codes.

EXCEPTION: Services provided in Place of Service (POS) "Home," and for any other place of service that contractors currently consider to be the same as "Home," there is no requirement for the submission of a ZIP code.

Effective January 1, 2011, for claims processed on or after January 1, 2011, submission of the location where the service was rendered will be required for **all** POS codes including "Home." This change will be effective for claims submitted on the 5010 version of the ANSI X12N 837 P electronic form and on the paper Form CMS-1500. Claims submitted on the 4010A1 electronic form are not impacted by this change. See CR 6947

MEDICARE PART B

Anesthesia

for more information:

<http://www.cms.gov/transmittals/downloads/R2041CP.pdf>

Claims received with a five-digit code that is one of the ZIP codes that cross localities and therefore requires a nine-digit ZIP code to be processed shall be treated as unprocessable.

For claims received that require a nine-digit ZIP code with a four-digit extension that does not match a four-digit extension on file, will be treated as unprocessable. Claims for ambulance and laboratory services will continue to be submitted and priced using five-digit ZIP codes.

ZIP code and county information may be found at the USPS Web site at <http://www.usps.com/>, or other commercially available sources of ZIP code information may be consulted.

MEDICARE PART B

Anesthesia

MULTIPLE ANESTHESIA SERVICES

Same Operative Session

Payment can be made for anesthesia services associated with multiple surgical procedures. The payment is based on the anesthesia procedure with the highest base unit value. The time units will equal the actual anesthesia time for both procedures.

Example:

Provider	Date of Service	Procedure	Time	Base Units
ABC	01/01/2009	00700 AA	2 hours	4
ABC	01/01/2009	00730 AA	1 hour	5

Payment for the multiple procedures will be based on code 00730, which has the highest base unit value, plus a total time period of three hours.

Modifier 76 – Repeat Procedure or Service by Same Physician

The patient is returned to the operating room on the same day for the same or a related procedure. The same physician who is performing the repeat service should bill the repeat procedure with the 76 modifier.

Example:

Provider	Date of Service	Procedure	Modifier
ABC	01/01/2009	00740	AA – First Service
ABC	01/01/2009	00810	AA, 76 – Repeat Service

Modifier 77 – Repeat Procedure by Another Physician

When a patient is taken back to surgery on the same day for the same or a related procedure by a different physician than the physician who performed the first service, submit the repeat procedure with the 77 modifier.

Example:

Provider	Date of Service	Procedure	Modifier
ABC	01/01/2009	00740	AA – First Service
XYZ	01/01/2009	00810	AA, 77 – Repeat Service

Anesthesia

MISCELLANEOUS

Blood Gas Monitoring

Blood gas monitoring performed as part of an anesthesiologist's service is considered to be an integral part of the anesthesia service and is not reimbursed separately.

Bundled Services

99100©	Special anesthesia service
99116©	Anesthesia with hypothermia
99135©	Special anesthesia procedure
99140©	Emergency anesthesia

Separate payment will not be allowed for these services; payment will be bundled into the anesthesia allowance.

Pre-Anesthetic Exams/Cancelled Surgery

A pre-anesthetic examination and evaluation of a patient who does not undergo surgery may also be considered for payment. Payment is determined under the physician fee schedule for the medical or surgical service. Non-medically directed CRNAs should report the pre-anesthetic examination and evaluation for a patient whose surgery is cancelled using one of the subsequent hospital care codes (99231–99233). It is inappropriate to use the initial hospital care codes. No separate payment will be made in cases of medically directed CRNAs because it is assumed the anesthesiologist furnished these services.

Locum Tenens

Locum Tenens does not pertain to a CRNA. CRNAs are required to have a Medicare number in any locality where they perform services.

Add-On Codes for Anesthesia

Anesthesia add-on codes are priced differently than multiple anesthesia codes. Only the base unit(s) of the add-on code will be allowed. All anesthesia time should be reported with the primary anesthesia code. See exception below in the obstetrical area.

Add-on codes for anesthesia involving burn excisions or debridement and obstetrical anesthesia are:

01952©	Anesth, burn 4-9 percent – primary code
01953©	Anesth, burn each 9 percent – add-on code
01967©	Anesth, analg vag delivery – primary code
01968©	Anes/analg cs deliver add-on – add-on code
01969©	Anesth/analg cs hyst add-on – add-on code

Anesthesia

The add-on codes should be billed in addition to the primary anesthesia code. For example, in the burn area, anesthesia time should be reported with code 01952. Anesthesia time would not be reported with the add-on code 01953. One unit (not time) per additional 9 percent total body surface area or part thereof should be reported with code 01953. This would be reported in the Days/Units field (Item 24g) on the CMS-1500 form or electronic equivalent.

There is an exception for obstetrical anesthesia. Therefore, Medicare requires for the obstetrical add-on codes, that the anesthesia time be separately reported with each of the primary and the add-on codes based on the amount of time appropriately associated with either code. Both the base unit and the time units for the primary and the add-on obstetrical anesthesia codes are recognized.

Electroconvulsive Therapy (ECT) – 90870

Electroconvulsive Therapy (ECT) is used in the treatment of depression and related disorders and other severe psychiatric conditions.

When a psychiatrist administers the anesthesia for the ECT procedure, no separate payment is made for the anesthesia service.

See the Local Coverage Determination (LCD) for ECT at:

<http://www.trailblazerhealth.com/Tools/LCDs.aspx>

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

Change Request (CR) 5618

Transmittal 1324

<http://www.cms.gov/Transmittals/Downloads/R1324CP.pdf>

Physicians who both perform and provide moderate sedation for medical/surgical services will be paid for the conscious sedation consistent with CPT guidelines. However, physicians who perform and provide local or minimal sedation for these procedures will not be paid separately for the sedation services.

Providers should ensure their billing staffs are aware of these payment policies that address the same physician performing both the medical/surgical service and the conscious sedation service.

The continuum of complexity in anesthesia services (from least intense to most intense) ranges from:

- Local or topical anesthesia.
- Moderate (conscious) sedation.

MEDICARE PART B

Anesthesia

- Regional anesthesia.
To,
- General anesthesia.

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. It does not include minimal sedation, deep sedation or monitored anesthesia care.

If the physician performing the procedure also provides moderate sedation for the procedure, payment may be made for conscious sedation consistent with CPT guidelines; however, if the physician performing the procedure provides local or minimal sedation for the procedure, no separate payment is made for the local or minimal sedation service.

Payment will not be allowed for codes 99148–99150 if any of these codes are performed on the same day with a medical/surgical service listed in Appendix G of the CPT book and the service is provided in a non-facility setting. A facility is defined as one with a place of service code of 21, 22, 23, 24, 26, 31, 34, 41, 42, 51, 52, 53, 56 or 61.

Prior to 2006, Medicare did not recognize separate payment if the same physician both performed the medical or surgical procedure and provided the anesthesia needed for the procedure. The final physician fee schedule published in the Federal Register November 21, 2005, included newly created codes (99143–99150) for moderate (conscious) sedation, which was added to CPT 2006.

Note: These codes have been assigned a status indicator of “C” under the Medicare physician fee schedule designating that these services are carrier-priced. CMS has not established relative value units for these services.

Three of these codes (99143, 99144 and 99145) describe the scenario in which the same physician performing the diagnostic or therapeutic procedure provides the moderate sedation, and an independent trained observer’s presence is required to assist in monitoring the patient’s level of consciousness and physiological status. The other three codes (99148, 99149 and 99150) describe the scenario in which the moderate sedation is provided by a physician other than the one performing the diagnostic or therapeutic procedure.

CR 5618 presents some specific points of which providers should be aware:

- CPT coding guidelines for conscious sedation codes instruct practices not to report codes 99143–99145 in conjunction with the codes listed in CPT Appendix G. Your carrier or A/B MAC will follow the National Correct Coding Initiative, which 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

Anesthesia

add-on code and it is not paid if the primary code is not paid.)

- In the unusual event that a second physician (other than the one performing the diagnostic or therapeutic services) provides moderate sedation in the facility setting for the procedures listed in CPT Appendix G, the second physician can bill codes 99148–99150 but cannot report these codes when the second physician performs these services (on the same day as a medical/surgical service) in the non-facility setting.
- If an anesthesiologist or CRNA provides anesthesia for diagnostic or therapeutic nerve blocks or injections, and a different provider performs the block or injection, the anesthesiologist or CRNA may report the anesthesia service using CPT code 01991. In this case, 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, 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, the conscious sedation code should not be reported.
- There is no CPT code for the performance of local anesthesia, and as such, payment for this service is considered to be part of the payment for the underlying medical or surgical service. Therefore, 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), the conscious sedation code should not be reported and the carrier or A/B MAC will allow no payment.

Documentation Requirements for Moderate (Conscious) Sedation

(“From the Desk of the Medical Director,” TrailBlazer Health Enterprises® eBulletin, April 2009)

The American Medical Association (AMA) issued new CPT codes for moderate (conscious) sedation in 2006. One set of codes is used when the operating physician, with the assistance of a trained observer, performs the moderate sedation. The other set is used when a physician other than the operating physician performs the sedation. These codes have distinct limitations described in the preamble to the codes in the CPT book. CMS issued Change Request (CR) 5618 in August 2007 further describing the use of these codes. In addition, Medicare has some general related requirements. A synopsis of all this information is provided below.

2009 CPT Code Descriptions

- 99143©: Moderate sedation services (other than those services described by codes 00100–01999) 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; younger than 5 years of age, first 30

Anesthesia

minutes intra-service time.

- 99144©: Moderate sedation services (other than those services described by codes 00100–01999) 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; age 5 years or older, first 30 minutes intra-service time.
- 99145©: Moderate sedation services (other than those services described by codes 00100–01999) 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; each additional 15 minutes intra-service time (list separately in addition to code for primary service).
- 99148©: Moderate sedation services (other than those services described by codes 00100–01999) provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; younger than 5 years of age, first 30 minutes intra-service time.
- 99149©: Moderate sedation services (other than those services described by codes 00100–01999) provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; age 5 years or older, first 30 minutes intra-service time.
- 99150©: Moderate sedation services (other than those services described by codes 00100–01999) provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports; each additional 15 minutes intra-service time (list separately in addition to code for primary service).

Limitations Based on the CPT Definitions

99143–99145

- An independent trained observer whose sole duty is to monitor the patient’s level of consciousness and physiological status must be present throughout the diagnostic or therapeutic service. The anesthesia note must identify this person and his credentials (e.g., RN, NPP, PA).
- “Intra-service time starts with the administration of the sedation agent(s), requires continuous face-to-face attendance, and ends at the conclusion of personal contact by the physician providing the sedation.” (Per CPT)
- Do not report 99143–99145 with codes listed in Appendix G of the CPT book. (These codes include payment for moderate sedation.)

99148–99150

- May be used only in a facility setting: hospital, outpatient hospital, Ambulatory Surgical Center (ASC), Skilled Nursing Facility (SNF).

MEDICARE PART B

Anesthesia

- Do not report 99148–99150 with codes listed in Appendix G if performed in a non-facility setting.
- “Intra-service time starts with the administration of the sedation agent(s), requires continuous face-to-face attendance, and ends at the conclusion of personal contact by the physician providing the sedation.” (Per CPT)
- The sedation service must be medically necessary for the management of the patient. Preliminary data analysis of claims submitted for these services indicates that 99144–99145 are being billed with routine injection services and other minor procedures for which moderate sedation may not be “reasonable.” Title XVIII of the Social Security Act, Section 1862(a)(1)(A), states “... No payment may be made under Part A or Part B for any expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”
- Report only the time of face-to-face physician contact, starting with the time when the physician starts the anesthesia to the time the physician breaks face-to-face contact. The reported time stops when the physician breaks face-to-face contact, even if the trained observer stays for a longer period of time to monitor recovery. The additional time the trained observer stays to monitor recovery after the physician leaves the patient’s bedside is not a service separately billable to Medicare. The Medicare “incident to” provisions do not apply to this service since the service is defined in terms of face-to-face physician time.
- These codes may not be used to report a level of anesthesia lower in intensity than moderate or conscious sedation such as local or topical anesthesia or minimal sedation.
- For this service, Medicare defines a “physician” as an MD, DO or other physicians and non-physician practitioners licensed by the state to perform conscious sedation in addition to the diagnostic or therapeutic service for which sedation is required.
- When billing 99143–99145, the physician performing the diagnostic or therapeutic service must also bill for the anesthesia service on the same claim and must be licensed to perform both the diagnostic or therapeutic service and the anesthesia service.
- Documentation must include a separate anesthesia note with a patient assessment, the method and route of administration of conscious sedation, start and stop times, baseline vital signs, vital signs every 5 to 15 minutes (depending on patient status), identity of trained observer (for codes 99143–99145), method of monitoring heart rate, oxygen saturation (if any) and recovery time.
- The provider must make the anesthesia note and the justification from the medical record of the medical necessity of the service available upon request.

Anesthesia

MONITORED ANESTHESIA CARE (MAC)

Description

To view the entire Local Coverage Determination (LCD) for Monitored Anesthesia Care (MAC), please refer to the Web page:

<http://www.trailblazerhealth.com/Tools/LCDs.aspx>

With advances in modern medical technology, there has been a shift in supplying some surgical and diagnostic services to an ambulatory, outpatient or office setting. Accompanying this, there has been a change in the provision of anesthesia services from the traditional general anesthetic to a combination of anxiolytic, hypnotic, amnestic and analgesic drugs. Monitored Anesthesia Care (MAC) is a specific anesthesia service for a diagnostic or therapeutic procedure. Indications for monitored anesthesia care include the nature of the procedure, the patient's clinical condition and/or the potential need to convert to a general or regional anesthetic.

Indications and Limitations of Coverage and/or Medical Necessity

- In keeping with the American Society of Anesthesiologists' standards for monitoring, MAC should be provided by qualified anesthesia personnel in accordance with individual state licensure. These individuals must be continuously present to monitor the patient and provide anesthesia care.
- During MAC, the patient's oxygenation, ventilation, circulation and temperature should be evaluated by whatever methods are deemed most suitable by the attending anesthetist. It is anticipated that newer methods of non-invasive monitoring such as pulse oximetry and capnography will be frequently relied upon. Close monitoring is necessary to anticipate the need for general anesthesia administration or for the treatment of adverse physiologic reactions such as hypotension, excessive pain, difficulty breathing, arrhythmias, adverse drug reactions, etc. In addition, the possibility that the surgical procedure may become more extensive, and/or result in unforeseen complications, requires comprehensive monitoring and/or anesthetic intervention.
- The following CMS requirements for this type of anesthesia should be the same as for general anesthesia with regard to:
 - The performance of pre-anesthetic examination and evaluation.
 - The prescription of the anesthesia care required.
 - The completion of an anesthesia record.
 - The administration of necessary medications and the provision of indicated postoperative anesthesia care.
- Appropriate documentation must be available to reflect pre- and post-anesthetic evaluations and intra-operative monitoring.

Anesthesia

- The MAC service rendered must be reasonable, appropriate and medically necessary.
- The anesthesia procedures listed in the LCD are examples of those that are usually provided by the attending surgeon and are included in the global fee and are not separately billable. In certain instances, however, MAC provided by anesthesia personnel, may be necessary for these procedures if the patient has one or more of the conditions or situations found in the ICD-9-CM Codes That Support Medical Necessity in the LCD. MAC may be necessary for these active and serious accompanying situations or conditions to ensure smooth anesthesia (and surgery) by the prevention of adverse physiologic complications. The use of anesthesia modifiers, when the CPT code is not fully descriptive, is required as follows:
 - **G8** Anesthesia Modifier – used to indicate certain deep, complex, complicated or markedly invasive surgical procedures. This modifier is to be applied to the following anesthesia codes only: 00100, 00300, 00400, 00160, 00532 and 00920.
 - **G9** Anesthesia Modifier – represents “a history of severe cardiopulmonary disease,” and should be utilized whenever the proceduralist feels the need for MAC due to a history of advanced cardiopulmonary disease. The documentation of this clinical decision making process and the need for additional monitoring must be clearly documented in the medical record.
 - Anesthesia codes utilized to indicated the clinical condition of the patient receiving MAC:
 - **P1** – Healthy individual with minimal anesthesia risk.
 - **P2** – Mild systemic disease.
 - **P3** – Severe systemic disease with intermittent threat of morbidity or mortality.
 - **P4** – Severe systemic illness with ongoing threat of morbidity or mortality.
 - **P5** – Pre-morbid condition with high risk of demise unless procedural intervention is performed.

Special conditions and/or criteria must be supported by documentation in the medical record.
- Reimbursement for MAC will be the same amount allowed for full general anesthesia services if all the requirements listed under these indications are met. The provision of quality MAC is mandatory and requires the same expertise and the same effort (work) as required in the delivery of a general anesthetic. If the requirements are not fulfilled or the procedures are unnecessary, payment will be denied in full.
- For procedures that do not usually require anesthesia services, MAC could be covered when the patient's condition requires the presence of qualified anesthesia personnel to perform monitored anesthesia in addition to the

Anesthesia

physician performing the procedure, and is so documented in the patient's medical record.

- The presence of an underlying condition alone, as reported by an ICD-9-CM diagnosis code, may not be sufficient evidence that MAC is necessary. The medical condition must be significant enough to impact on the need to provide MAC such as the patient being on medication or being symptomatic, etc. The presence of a stable, treated condition, of itself, is not necessarily sufficient.
- Conditions listed under the “Diagnoses That Support Medical Necessity” section of the LCD, if matched with anesthesia procedures in the “CPT/HCPCS Codes” section of the LCD, could support the need for MAC. Other disease states can also be considered if medical justification is demonstrated.

Note: The QS modifier must be used with the anesthesia service provided if MAC is delivered. This modifier will follow the modifier that indicates who provided the service (AA QS).

The CPT/HCPCS codes listed in the LCD will be subjected to “procedure to diagnosis” editing. If a covered diagnosis found in the LCD is not on the claim, the edit will automatically deny the service as not medically necessary.

MEDICARE PART B

Anesthesia

REVISION HISTORY

Date	Section	Description
July 2009	Anesthesia Services	<ul style="list-style-type: none"> Added note to modifiers. Updated claim form example. Provided Web link for the “Part B Crosswalk to the CMS-1500 Claim Form” for electronic claims. Added information for teaching physician.
	Medicare Anesthesia Base Units	Added CMS Web link for anesthesia base units.
	Miscellaneous	Added article from TrailBlazer® eBulletin, April 2009. Documentation requirements for moderate (conscious) sedation.
December 2009	Anesthesia Services	<ul style="list-style-type: none"> Defined personally performed services as in IOM, Pub. 100-04, Chapter 12, Section 100. Revised teaching anesthesiologists’ and teaching CRNAs’ payment method based on CR 6706. Updated description of GC modifier.
	Conversion Factors	Removed 2009. Use Web link for any given year.
August 2010	Anesthesia Services	Added to the payment conditions for personally performed services and medical direction as found in IOM, Pub. 100-04, Chapter 12, Section 50.
	Anesthesia Time	Updated claim form example.
	Medicare Anesthesia Base Units	Removed the list of procedure codes and base units and replaced with CMS Web link for the most current base units.
	Reimbursement Examples	Added note to include location of where the services were rendered in Item 32 of the CMS-1500 form (CR 6947).
<i>September 2011</i>	<i>Anesthesia Services</i>	<i>Added link to CMS-1500 Claim Form and Unprocessable/Rejected Claims Manual.</i>
	<i>Anesthesia Time</i>	<i>Added link to CMS-1500 Claim Form and Unprocessable/Rejected Claims Manual.</i>