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Anesthesia Payment Basics Series: #3 Anesthesia Modifiers and Payment Determination

To properly and accurately report anesthesia services, one must know and adhere to rules and guidelines that are specific to anesthesia care. Additionally, the formula used to determine payment for anesthesia services is unique to anesthesia. These rules and formula may be misunderstood or improperly applied. This ASA Timely Topic is the third of a series that will break the components of anesthesia billing and payment down into individual components and provide explanation on what the components represent.

Anesthesia Modifiers and Payment Determination

The first article in this series covered CPT®, HCPCS and ICD-10-CM – important tools applicable to coding and billing across all specialties and types of care. The second piece provided information on the coding resources that are specific to anesthesia. Because anesthesia care is provided under a variety of scenarios, proper billing and coding *and payment* requires an understanding of the modifiers that are used to communicate how the care was provided as well as how they impact payment.

Government and most commercial payers recognize that anesthesia care can be personally performed by the physician anesthesiologist or performed by a team of qualified anesthesia providers in which the anesthesiologist either directs or supervises the care. In some instances when done in a way that complies with applicable state law, anesthesia care is provided by a nurse anesthetist without the direction or supervision of an anesthesiologist. To communicate the scenario and to ensure accurate payment determination, claims for anesthesia care include modifiers specific to each scenario. This Timely Topic covers the billing scenarios and shows how Medicare will allocate the payment for anesthesia services under each of them.

The modifiers and concepts discussed here are applicable to anesthesia care as described by CPT codes 00100-01999. They do not pertain to other services such as pain medicine, intravascular catheterization and transesophageal echocardiography. Neither do they apply to moderate sedation services.

The information below is taken from the [Medicare Claims Processing Manual, Chapter 12](#), Sections 50, 100 and 140 as of August 26, 2019).

Modifier AA: Anesthesia Services performed personally by the anesthesiologist

Under this scenario, the physician anesthesiologist

- performs the entire anesthesia service, or
- is involved in training residents in up to two concurrent cases meeting teaching physician requirements (reporting requires both modifier AA and modifier GC - *These services have been performed by a resident under the direction of a teaching physician, or*
- is continuously involved in a single case with a student nurse anesthetist.

Modifier AA may also apply in extraordinary circumstances in which the services of two anesthesiologists, or an anesthesiologist and a nurse anesthetist or anesthesiologist assistant are medically necessary. The physician anesthesiologist receives 100% of the allowed amount for cases reported with the AA modifier. (*Applicable for Medicare, private payers' policy may vary*)

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

Medical supervision occurs when the anesthesiologist is

- involved in more than four (4) concurrent anesthesia services, or
- performs other services while directing anesthesia care.

Medicare contractors allow three (3) base units for medical supervision of anesthesia care with one additional unit if documentation demonstrates that the anesthesiologist was present during induction.

Modifier QK: Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals

Modifier QY: Medical direction of one qualified nonphysician anesthetist by an anesthesiologist
The Centers for Medicare & Medicaid Services (CMS) requires that a medically directing anesthesiologist must:

- Perform a pre-anesthetic examination and evaluation
- Prescribe the anesthesia plan
- Personally participate in the most demanding procedures in the anesthesia plan, including, if applicable, induction and emergence
- Ensure that any procedures in the anesthesia plan that he/she does not perform are performed by a qualified individual
- Monitor the course of anesthesia at frequent intervals
- Remain physically present and available for immediate diagnosis and treatment of emergencies
- Provide indicated post anesthesia care.

It is important to note that when counting concurrent cases, *all cases matter*. Concurrency counts are not limited only to those cases that involve Medicare beneficiaries -- and there cannot be even one minute of overlap among any of the cases.

There are limits on the activities an anesthesiologist may perform while providing medical direction. These are interruptible and allow the anesthesiologist to maintain the necessary level of involvement in the medically directed cases to be available for immediate diagnosis and treatment of emergencies.

The Medicare Claims Processing Manual states,

“A physician who is concurrently furnishing services that meet the requirement 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 patient 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.”

Also, review the [ASA Definition of “Immediately Available” When Medically Directing.](#)

Modifier QX: Qualified nonphysician anesthetist service: With medical direction by a physician

This modifier is reported by the medically directed nurse anesthetist or anesthesiologist assistant. A corresponding claim for medical direction (with the same CPT Anesthesia code with modifier QK or QY) would be submitted by the physician anesthesiologist. Medicare payment for this service is split between the two anesthesia professionals with 50% of the allowed amount paid to the anesthesiologist and 50% to the nurse anesthetist or anesthesiologist assistant.

While not specifically addressed in the Medicare Claims Processing Manual, a QX claim would also match with a claim with the AD modifier.

Modifier QZ: CRNA service: Without medical direction by a physician

This modifier is specific to nurse anesthetists and should not be reported by anesthesiologist assistants. In this scenario, a nurse anesthetist provides care under the supervision of or via a collaborative arrangement with the surgeon of other mode as permitted by state law; medical direction by a physician anesthesiologist is not present.

The nurse anesthetist receives 100% of the allowed amount for cases reported with the QZ modifier. *(Applicable for Medicare, private payers' policy may vary)*

Putting It Together

A 67-year-old Medicare beneficiary undergoes a total hip arthroplasty as described by CPT[®] code 27130 - *Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft*. The ASA CROSSWALK[®] links this procedure to the anesthesia care described by code 01214 - *Anesthesia for open procedures involving hip joint; total hip arthroplasty* – which has 8 base units. In our example, reported anesthesia time is 129 minutes. Since Medicare uses a 15-minute time unit and calculates time out to one decimal point, these 129 minutes will be converted to 8.6 time units. (Remember, report anesthesia time in actual minutes on your claims.)

Medicare payment for an anesthesia service is calculated by adding the base units as assigned to the anesthesia code with the time units as determined from the time reported on the claim and multiplying that sum by a conversion factor which is the dollar per unit amount. For CY 2019, the Medicare Anesthesia Conversion factor is \$22.2730.

$$(8 \text{ base units} + 8.6 \text{ time units}) * \$22.2730 = \$452.73.$$

After deductible is met, Medicare will pay 80% of the allowed amount and the patient is responsible for the remaining 20%. The following chart illustrates how the Medicare payment of \$362.18 (\$452.73*0.80) is distributed between the anesthesia professionals under the scenarios described above.

	Payment to Physician Anesthesiologist	Payment to Nonphysician Anesthetist
Personally performed by physician anesthesiologist (Modifier AA)	\$362.18	No payment
Medical Direction (Modifiers QK/ QY and QX)	\$181.09	\$181.09
Medical Supervision (anesthesiologist present at induction) (Modifiers AD and QX)	\$109.09	\$181.09
Medical Supervision (anesthesiologist not present at induction) (Modifiers AD and QX)	\$81.82	\$181.09
CRNA service without direction (Modifier QZ)	No payment	\$362.18*

**Not applicable to anesthesiologist assistants*