

	Reimbursement Policy Manual		Policy #:	RPM034
Policy Title:	Modifiers AA, AD, GC, QK, QX, QY, QZ - Anesthesia Payment Modifiers			
Section:	Anesthesia	Subsection:	Modifiers	
<p>Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:</p> <p>Companies: <input checked="" type="checkbox"/> All Companies: Moda Partners, Inc. and its subsidiaries & affiliates <input type="checkbox"/> Moda Health Plan <input type="checkbox"/> Moda Assurance Company <input type="checkbox"/> Summit Health Plan <input type="checkbox"/> Eastern Oregon Coordinated Care Organization (EOCCO) <input type="checkbox"/> OHSU Health IDS</p> <p>Types of Business: <input checked="" type="checkbox"/> All Types <input type="checkbox"/> Commercial Group <input type="checkbox"/> Commercial Individual <input type="checkbox"/> Commercial Marketplace/Exchange <input type="checkbox"/> Commercial Self-funded <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare Advantage <input type="checkbox"/> Short Term <input type="checkbox"/> Other: _____</p> <p>States: <input checked="" type="checkbox"/> All States <input type="checkbox"/> Alaska <input type="checkbox"/> Idaho <input type="checkbox"/> Oregon <input type="checkbox"/> Texas <input type="checkbox"/> Washington</p> <p>Claim forms: <input checked="" type="checkbox"/> CMS1500 <input checked="" type="checkbox"/> CMS1450/UB (or the electronic equivalent or successor forms)</p> <p>Date: <input checked="" type="checkbox"/> All dates <input type="checkbox"/> Specific date(s): _____ <input type="checkbox"/> Date of Service; For Facilities: <input type="checkbox"/> n/a <input type="checkbox"/> Facility admission <input type="checkbox"/> Facility discharge <input type="checkbox"/> Date of processing</p> <p>Provider Contract Status: <input checked="" type="checkbox"/> Contracted directly, any/all networks <input checked="" type="checkbox"/> Contracted with a secondary network <input checked="" type="checkbox"/> Out of Network</p>				
Originally Effective:	12/8/2005	Initially Published:	9/30/2013	
Last Updated:	9/20/2023	Last Reviewed:	9/20/2023	
Last update payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)?			No	
Last Update Effective Date for Texas:		9/20/2023		

Reimbursement Guidelines

A. General

1. Anesthesia services must be submitted with an appropriate anesthesia payment modifier to indicate the number of providers and roles involved in the anesthesia service.
2. Effective for claims processed on or after July 1, 2018, regardless of date of service, claims for anesthesia services submitted without an appropriate payment modifier will be denied as a billing error for lack of a required modifier. A corrected claim will need to be submitted with the appropriate modifier(s) added.
3. One anesthesia provider at a time shall be reimbursed per patient. The only exception is supervised anesthesia services by a CRNA under the medical direction of a physician.
4. If two anesthesia services claims are received for the same patient, same date of service, and the payment modifiers do not agree about the medical direction or supervision performed, the first claim processed will be allowed.
 - a. The second claim processed is subject to denial as a billing error due to lack of consistent information about who performed the service.

- b. No adjustment for reimbursement to the second anesthesia provider can be made until a corrected claim is received from the first (allowed) anesthesia provider so that the payment modifiers on both claims agree about who performed which responsibilities in the anesthesia service.
- c. The billing office for the denied claim is responsible to contact the billing office for the other anesthesia provider involved (supervised CRNA or physician providing medical direction) and arrange for the submission of the needed corrected claim.

B. Physician Anesthesia Services

- 1. Personally performed.
 - a. Report anesthesia services personally performed by the anesthesiologist with modifier AA.
 - b. Personally performed services will be reimbursed at the full applicable fee schedule rate (base units + time units).
- 2. Medically directed.
 - a. When the anesthesiologist is involved in specific aspects of anesthesia services performed by other qualified individuals, the services are considered to be “medically directed.”
 - i. “Qualified individuals” includes: CRNAs, anesthesiologists’ assistants, residents, or combinations of these individuals.
 - b. Specific CMS requirements and conditions for medically directed anesthesia services must be met. (CMS⁴)
 - c. The anesthesiologist may not perform other services while medically directing anesthesia procedures.
 - d. Medical direction of one qualified nonphysician anesthesia procedure.
 - i. Report medical direction of one CRNA anesthesia procedure with modifier QY.
 - ii. Services submitted with modifier QY will be reimbursed at 50% of the applicable fee schedule rate.
 - e. Medical direction of 2-4 concurrent anesthesia procedures.
 - i. When two to four concurrent anesthesia procedures are medically directed, report with modifier QK.
 - ii. Services submitted with modifier QK will be reimbursed at 50% of the applicable fee schedule rate.
- 3. Medically supervised.
 - a. When the anesthesiologist is involved in furnishing more than four procedures concurrently or is performing other services while directing the concurrent procedures, the services are considered to be “medically supervised.”
 - b. CMS standards are used to determine if other services were performed while directing concurrent procedures. (CMS⁴)
 - c. Report medically supervised anesthesia services with modifier AD.

- d. Services submitted with modifier AD will be reimbursed at the applicable fee schedule rate for three base units per procedure.
 - i. No time units will be reimbursed for medically supervised anesthesia services.
 - ii. Upon written appeal, one 15 minute time unit may be allowed in addition to the three base units, if the physician submits written documentation showing they were personally present in addition to the supervised anesthesia provider at the time of anesthesia induction.

4. Teaching services.

Claims for direction of residents and/or student nurse anesthetists should be submitted with proper modifiers attached to the anesthesia codes.

- a. In order to bill for anesthesia procedures, the teaching physician must be present during all critical and key portions of the procedure and be immediately available to furnish services during the entire procedure.
- b. Services by the teaching physician when directing a single resident or student nurse:
 - i. If the teaching physician was directing a resident, report with [modifier AA*](#) and GC.
 - ii. If the teaching physician was directing one qualified nonphysician anesthetist (for example: CRNA, anesthesiologist's assistant, student), report with modifier QY.
- c. Services by the teaching physician when directing two concurrent anesthesia procedures:
 - i. If directing two residents performing concurrent cases, report with [modifiers AA*](#) and GC.
 - ii. If directing one resident and one other qualified nonphysician anesthetist performing concurrent cases:
 - Report the direction of the resident with [modifiers AA*](#) and GC.
 - Report the direction of the qualified nonphysician anesthetist with modifier QK.
 - iii. If directing two qualified nonphysician anesthetists performing concurrent cases, report the direction of both cases with modifier QK.
- d. Services by the teaching physician must be submitted with modifier QK when directing three, or four residents, student nurse anesthetists, or CRNAs concurrently.
- e. No reimbursement is made to residents or student nurse anesthetists.
- f. *Note: Modifier AA may only be reported by the teaching physician if the resident performs the entire case. If the resident performs a specific portion of the case (e.g., intubation, induction, placement of epidural, nerve block, etc.) and then hands off the case to a CRNA or other provider who completes the case, the service was no longer personally performed by the resident and teaching physician. Instead, the lower anesthesia payment modifier is selected/applies.
- g. If the teaching physician hands off the case to another physician providing medical direction or supervision, the anesthesia payment modifier is also selected based upon the highest number of concurrent cases overseen by any of the supervising physicians involved throughout the case (duration of the patient's anesthesia).
- h. Modifier GC does not alter the reimbursement level for modifiers AA, QY, QK, or AD. Append modifier GC in combination with any of these modifiers as appropriate to indicate the service was performed in part by a resident.

C. CRNA Services

1. Personally performed.
 - a. Report personally performed CRNA anesthesia services with modifier QZ.
 - b. Anesthesia services submitted with modifier QZ will be reimbursed at the full applicable CRNA fee schedule rate, as the CRNA personally performed the full anesthesia service without medical direction or supervision by a physician.
2. Medically directed.
 - a. Report modifier QX for CRNA anesthesia services provided with medical direction by a physician.
 - b. Services submitted with modifiers QX will be reimbursed at 50% of the applicable fee schedule rate, due to the supervision/services shared between two providers.

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation		Definition
AMA	=	American Medical Association
CCI	=	Correct Coding Initiative (see "NCCI")
CMS	=	Centers for Medicare and Medicaid Services
CPT	=	Current Procedural Terminology
CRNA	=	Certified Registered Nurse Anesthetist
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	=	Health Insurance Portability and Accountability Act
MS DRG	=	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	=	National Correct Coding Initiative (aka "CCI")
RPM	=	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
UB	=	Uniform Bill

Definition of Terms

Term	Definition
Critical or Key Portion	That part (or parts) of a service that the teaching physician determines is (are) a critical or key portion(s). For purposes of this policy, these terms are interchangeable.

Term	Definition
Medically directed	When the anesthesiologist is involved in specific aspects of anesthesia services performed by other qualified individuals and is not performing any other services while directing the concurrent procedures, the services are considered to be "medically directed."
Medically supervised	When the anesthesiologist is involved in furnishing more than four procedures concurrently or is performing other services while directing the concurrent procedures, the services are considered to be "medically supervised."
Physically Present	The teaching physician is located in the same room (or partitioned or curtained area, if the room is subdivided to accommodate multiple patients) as the patient and/or performs a face-to-face service.
Resident	An individual who participates in an approved graduate medical education (GME) program or a physician who is not in an approved GME program but who is authorized to practice only in a hospital setting. The term includes interns and fellows in GME programs recognized as approved for purposes of direct GME payments made by the FI. Receiving a staff or faculty appointment or participating in a fellowship does not by itself alter the status of "resident". Additionally, this status remains unaffected regardless of whether a hospital includes the physician in its full time equivalency count of residents.
Student	An individual who participates in an accredited educational program (e.g., a medical school) that is not an approved GME program. A student is never considered to be an intern or a resident.
Teaching Physician	A physician (other than another resident) who involves residents in the care of his or her patients.

Modifier Definitions:

Modifier	Modifier Description & Definition
Modifier AA	Anesthesia services performed personally by anesthesiologist
Modifier AD	Medical supervision by a physician: more than 4 concurrent anesthesia procedures
Modifier GC	This service has been performed in part by a resident under the direction of a teaching physician
Modifier QK	Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals
Modifier QX	Qualified nonphysician anesthetist with medical direction by a physician
Modifier QY	Medical direction of one qualified nonphysician anesthetist by an anesthesiologist
Modifier QZ	CRNA service: without medical direction by a physician

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

Medicare:

“The Part B Contractor determines payment for the physician’s medical direction service furnished on or after January 1, 1998, on the basis of 50 percent of the allowance for the service performed by the physician alone.” (CMS⁴)

Cross References

- A. [“Anesthesia Physical Status Modifiers \(P1 - P6\).”](#) Moda Health Reimbursement Policy Manual, RPM032.
- B. [“Qualifying Circumstances for Anesthesia.”](#) Moda Health Reimbursement Policy Manual, RPM033.

References & Resources

1. CMS. *National Correct Coding Initiative Policy Manual*. Chapter 2 Anesthesia Services.
2. NHIC, Corp. *Anesthesia Billing Guide*. NHIC, Corp. A CMS Intermediary J14 A/B. April 2013: 18.
3. “Anesthesia Fast Facts.” American Society of Anesthesiologists. August 6, 2013. <http://www.asahq.org/For-the-Public-and-Media/Press-Room/Anesthesia-Fast-Facts.aspx> .
4. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 50.
5. CMS. *Medicare Claims Processing Manual* (Pub. 100-4). Chapter 12 – Physician Practitioner Billing, § 100, 100.1.2.A.4.

Background Information

Modifiers

Modifiers are two-character suffixes (alpha and/or numeric) that are attached to a procedure code. CPT modifiers are defined by the American Medical Association (AMA). HCPCS Level II modifiers are defined by the Centers for Medicare and Medicaid Services (CMS). Like CPT codes, the use of modifiers requires explicit understanding of the purpose of each modifier.

Modifiers provide a way to indicate that the service or procedure has been altered by some specific circumstance but has not been changed in definition or code. Modifiers are intended to communicate specific information about a certain service or procedure that is not already contained in the code definition itself. Some examples are:

- To differentiate between the surgeon, assistant surgeon, and facility fee claims for the same surgery
- To indicate that a procedure was performed bilaterally
- To report multiple procedures performed at the same session by the same provider
- To report only the professional component or only the technical component of a procedure or service

- To designate the specific part of the body that the procedure is performed on (e.g., T3 = Left foot, fourth digit)
- To indicate special ambulance circumstances

More than one modifier can be attached to a procedure code when applicable. Not all modifiers can be used with all procedure codes.

Modifiers do not ensure reimbursement. Some modifiers increase or decrease reimbursement; others are only informational.

Modifiers are not intended to be used to report services that are "similar" or "closely related" to a procedure code. If there is no code or combination of codes or modifier(s) to accurately report the service that was performed, provide written documentation and use the unlisted code closest to the section which resembles the type of service provided to report the service.

Anesthesia

Anesthesia is the administration of a drug or anesthetic agent by an anesthesiologist or Certified Registered Nurse Anesthetist (CRNA) for medical or surgical purposes to relieve pain and/or induce partial or total loss of sensation and/or consciousness during a procedure. A variety of levels of anesthesia exist, ranging from local through general anesthesia. "As physicians, anesthesiologists are responsible for administering anesthesia to relieve pain and for managing vital life functions during surgery." (ASA³)

Supervised Anesthesia

At times a physician will provide medical direction and oversight for a qualified anesthetist (CRNA) or a resident/student performing anesthesia services. The physician may supervise a CRNA, resident, or student nurse anesthetist in a single anesthesia case or the physician may be medically directing 2, 3, or 4 concurrent procedures. Specific modifiers exist to designate the medical direction provided, the number of cases which are supervised, and whether or not the CRNA services were performed under the supervision or medical direction of a physician.

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
9/20/2023	Formatting/Update: Cross References: 1 hyperlink updated.
12/14/22	Formatting/Update Scope, States: Idaho added. Cross References: Hyperlinks added.
6/8/2022	Formatting/Update: Change to new header. Acronym table: 1 entry added. Policy History section: Added. Entries prior to 2022 omitted (in archive storage).
9/30/2013	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
12/8/2005	Original Effective Date (with or without formal documentation). Policy based on...