

**Distribution:** Hospital 01-07  
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**Issued:** April 1, 2001

**Subject:** Policy to Recognize Medical Direction for Anesthesia Services,  
Direct Enrollment and Reimbursement of Certified Registered  
Nurse Anesthetists

**Effective:** May 1, 2001

**Programs Affected:** Medicaid, Children's Special Health Care Services,  
State Medical Program

The purpose of this bulletin is to update Medicaid coverage and reimbursement policy for the provision of anesthesia services. This policy change is based on Medicare guidelines and state law and will begin to implement changes in the Medicaid program to comply with national coding and billing standards. Effective for anesthesia services provided on and after May 1, 2001, the program will:

- recognize medically directed anesthesia care and reimburse a physician and a CRNA consistent with current anesthesia reimbursement practice.
- allow direct enrollment and reimbursement to Certified Registered Nurse Anesthetists (CRNAs).

Under this policy CRNAs are expected to fully comply with Michigan scope of practice licensing laws and regulations. Direct enrollment and reimbursement of CRNAs is for billing convenience only.

### **Enrollment of CRNAs**

Currently, CRNAs that are employed by or contracted with a hospital are enrolled in Medicaid and payment is made to the hospital. Effective for services rendered on or after May 1, 2001, a CRNA who provides service to Medicaid beneficiaries under fee-for-service must be enrolled in the program with an individual provider ID number. If a CRNA is currently enrolled as a hospital based provider, there is no need to re-enroll. Payment for covered services will be reimbursed to the CRNA or to the entity with which the CRNA has an employment or contract relationship that provides for payment to be made to that entity. Provider enrollment forms can be obtained

by calling 517-335-5492 or by writing to: Provider Enrollment Unit, Medical Services Administration, P.O. Box 30238, Lansing, MI 48909. In Michigan, a CRNA must be currently licensed as a nurse and certified by the state as a CRNA.

If a rural hospital elects reasonable cost reimbursement for CRNA services under Medicare, then no direct bill for the CRNA anesthesia services can be submitted to the program. The CRNA costs are included in facility payments to the hospital.

### **Medically Directed Anesthesia Services**

Effective for services provided on and after May 1, 2001, the program will make separate payment to physicians and CRNAs for medically directed anesthesia services consistent with anesthesia team practice. The program will recognize medical direction of general anesthesia, regional anesthesia, and reasonable and medically necessary Monitored Anesthesia Care (MAC). The physician cannot medically direct more than four concurrent anesthesia cases at one time and cannot perform any other services during the same period of time (except as explained below). In all cases in which medical direction is furnished, the physician must be physically present in the operating suite.

All of the following conditions must be met for medically directed anesthesia services to be reimbursed to the physician. For each patient, the physician 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 or she does not perform are performed by a qualified individual;
- Monitor the course of anesthesia administration at frequent intervals;
- Remain physically present and available for immediate diagnosis and treatment of emergencies; and
- Provide indicated post-anesthesia care.

The medical direction service furnished by a physician is not covered if the physician directs other than a qualified individual. A qualified individual is a CRNA, a student anesthetist, an anesthesiologist's assistant, or an intern or resident.

The physician must document in the patient's medical record that he or she performed the pre-anesthetic exam and evaluation, provided indicated post-anesthesia care, was present during some portion of the anesthesia monitoring, and present during the most demanding procedures, including induction and emergence, where indicated. Total anesthesia time must also be clearly indicated in the medical record.

If anesthesiologists are in group practice, one physician member may provide the pre-anesthesia examination and evaluation while another fulfills the other criteria. Similarly, one physician member of the group may provide post-anesthesia care while another member of the group furnishes the other component parts of the anesthesia service. However, the medical record must indicate that the services were furnished by physicians and identify the physicians who rendered them.

A physician who is concurrently directing the administration of anesthesia to not more than four surgical patients should ordinarily not be involved in furnishing additional services to other patients. However, addressing an emergency of short duration in the immediate area, or 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, a physician may receive patients entering the operating suite for subsequent surgeries, or may check on or discharge patients from the recovery room and may handle scheduling matters while directing concurrent anesthesia procedures without affecting payment for medical direction. However, if the physician leaves the immediate area of the operating suite for other than short durations, devotes extensive time to an emergency case or is otherwise not available to respond to the immediate needs of surgical patients, the physician's services are supervisory. Payment for medical direction will not be made.

An anesthesiologist who may be involved in furnishing more than four concurrent anesthesia procedures, or who is performing other services while directing the concurrent procedures, may be reimbursed for medically supervised anesthesia service in select instances. The physician must personally provide the pre-anesthesia exam and evaluation, prescribe the anesthesia plan, and be in the operating suite during the entire procedure. The program will allow a small flat rate payment equal to three ABUs and no time units to account for the physician's involvement in pre-surgical anesthesia services. If a physician routinely supervises more than four concurrent cases or performs other services while directing concurrent procedures, then the physician's services are supervisory and become the responsibility of the facility. No separate charge or payment will be made. Medically supervised CRNA services should be reported with modifier QX and are reimbursed at 50% of the calculated rate.

Medicaid will reimburse for anesthesia services consistent with Medicare when provided under an "attending physician" relationship in a teaching hospital and/or in accordance with the reimbursement and coverage guidelines established by the Medicare payment policies for teaching physicians.

### **Nonmedically Directed Anesthesia Services by the CRNA**

Anesthesia services provided by a CRNA under the supervision of the surgeon or another physician who is immediately available if needed are covered as nonmedically directed anesthesia services. The program will reimburse the CRNA for these services if the following conditions are met:

- the facility in which the services are rendered ensures that the anesthesia services are provided in a well-organized manner under the supervision of a qualified doctor of medicine or osteopathy,
- the facility is responsible for all anesthesia administered in the facility,
- a pre-anesthetic exam and evaluation is provided within 48 hours of the surgery by a physician (MD or DO) or a CRNA under the supervision of a physician,
- an intra-operative anesthesia record is provided which documents the CRNA providing the anesthesia service and the supervising physician,
- for inpatients, a post-anesthesia follow-up report is written within 48 hours after surgery by the person administering the anesthesia, and
- for outpatients, a post-anesthesia evaluation for proper anesthesia recovery is performed in accordance with the policies and procedures approved by the medical staff.

There is no separate payment allowed for any portion of the nonmedically directed anesthesia services. The physician's supervisory service is considered part of the facility service where the surgery is performed. The pre-anesthetic exam and post-anesthesia evaluation is included in the anesthesia payment for the CRNA nonmedically directed care and cannot be separately billed to the program. Payment for the nonmedically directed anesthesia service provided by the CRNA will be reimbursed to the CRNA or employing entity.

There is no separate payment for any anesthesia services performed by the physician who is performing the medical or surgical service requiring anesthesia. Any anesthesia service provided personally by the surgeon is included in the payment for the surgical procedure itself and will not be paid separately.

### **Monitored Anesthesia Care (MAC)**

MAC will be reimbursed on the same basis as other anesthesia services as long as it is reasonable and medically necessary. MAC involves the intra-operative monitoring by a physician, or by a qualified anesthesia provider under the medical direction of a physician, or by a CRNA under the supervision of a physician of the patient's vital physiological signs, in anticipation of the need for administration of general anesthesia or the development of adverse physiological patient reaction to the surgical procedure. It also includes the performance of a pre-anesthetic examination and evaluation, prescription of the anesthesia care required, administration of any necessary oral or parenteral medications (e.g., atropine, Demerol, Valium) and provision of indicated post-operative anesthesia care. The monitored anesthesia care and service must be reasonable and medically necessary under the given circumstances in order to be covered under the program.

## **Medical and Surgical Services Furnished in Addition to Anesthesia Services**

Separate payment may be made for certain reasonable and medically necessary medical or surgical services furnished by a physician while furnishing anesthesia services to the patient. The services may be furnished in conjunction with the anesthesia procedure to the patient or as single services, e.g., the day of or the day before the anesthesia service. These services may include insertion of a Swan Ganz catheter, the insertion of central venous pressure lines, emergency intubation and critical care. These services are paid the lesser of the fee screen or the provider's charge. No separate payment for medical or surgical services, such as the pre-anesthetic examination of the patient, pre- or post-operative visits, or usual monitoring functions, that are ordinarily included in the anesthesia service will be made.

Anesthesia services for labor and delivery allow the physician (or CRNA under the physician's supervision) to bill for the insertion of the epidural catheter separate from anesthesia services for the delivery. The epidural insertion should be billed as a surgical service, type of service 2. Anesthesia services provided by a physician or CRNA during delivery should be billed with type of service 7, using the policies that apply to general or monitored anesthesia care. Time units may be reported for the actual delivery time only and cannot be reported for time spent in labor.

There is no separate payment made for any services ordinarily provided as part of the anesthesia service. This includes the pre-anesthetic examination of the patient, pre- or post-operative visits, intubation, and normal monitoring functions.

## **Post-operative Pain Management**

Post-operative pain management is the responsibility of the surgeon (except in special circumstances) and is part of the global fee paid to the surgeon which includes all care after surgery. If a surgeon's patients routinely receive post-operative pain management services from an anesthesiologist, then the surgeon's fee will be reduced.

In cases where a continuous epidural is placed to manage post-operative pain, the physician (or CRNA under a physician's supervision) may bill the code for a continuous epidural only when placed for post-operative pain management and not used as the mode of anesthesia in the surgical case. If provided on the same day as surgery, the remarks must indicate that the catheter was not placed for use as an anesthetic during surgery. Daily management of a continuous epidural on subsequent post-operative days should be billed with procedure code 01996 and type of service 9. A flat rate payment will be made to the physician. Placement of a continuous epidural and post-operative daily management services (01996) will not be payable on the same day.

## **Anesthesia Time**

Anesthesia time means the time during which the anesthesia provider (physician providing anesthesia or the CRNA) is present with the patient. It starts when the anesthesia provider begins to prepare the patient for induction of anesthesia and ends when the anesthesia provider is no longer furnishing anesthesia services to the beneficiary. That is, when the beneficiary may be safely placed under post-operative supervision and the anesthesia provider is no longer in

personal attendance. 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 provider can add blocks of anesthesia time around interruption(s) in anesthesia time as long as the anesthesia provider is furnishing continuous anesthesia care within the time periods around the interruption. The anesthesia time must be documented in the medical record with begin and end times noted.

**Time should be reported in actual minutes effective for dates of service on and after May 1, 2001.** Physicians and CRNAs should report a quantity of "1" for each minute of anesthesia time. For example, if anesthesia time is 37 minutes, the quantity would be reported as 37. The program will convert the actual minutes reported to anesthesia time units. One anesthesia time unit is equivalent to 15 minutes of anesthesia time, and fractions of a 15-minute period are recognized as fractions of an anesthesia time unit. So, 37 minutes will be converted to 2.5 time units for purposes of calculating a payment rate.

### **Payment Calculation**

Anesthesia services are calculated using anesthesia base units (ABUs), time units, an established conversion factor and reported modifiers. Base units account for all other activities other than anesthesia time which include usual pre-operative and post-operative visits, administration of fluids and/or blood incident to anesthesia care, and monitoring services. The base units for each surgical procedure are specified in the Michigan Procedure Coding manual and should **not** be included in the reported time units (quantity). Time is reported only for type 7 anesthesia services, using a quantity of "1" for each minute of anesthesia time. Modifiers must be reported for each anesthesia service billed to the program and will determine the level of reimbursement for physician and CRNA anesthesia services. No additional payment will be made for patient risk factors such as patient age, health status, or other risk factors.

Payment for anesthesia services will be the product of time units and base units multiplied by a set conversion factor. Payment will be the calculated fee screen or the provider's charge, whichever is less. If a physician personally provides the entire anesthesia service, payment will be 100% of the calculated fee screen. Medically directed anesthesia services will be reimbursed at 50% of the calculated fee screen for both the CRNA and the physician. Medically supervised anesthesia services are paid at a flat rate of 3 ABUs for the physician and 50% of the calculated fee screen for the CRNA. Nonmedically directed CRNA services are reimbursed at 100% of the calculated fee screen. Physician supervision services are not reimbursed separately.

If multiple surgical procedures are performed on the same patient, anesthesia services must be reported on one line using the major surgical procedure code (the code with the highest ABUs) and the total time in minutes for the entire surgical session.

If two separate surgical sessions are provided on the same day to the same patient, each should be billed on a separate claim line and the remarks must indicate that two separate and distinct operative sessions were performed on the same day.

If a surgery is cancelled after the pre-anesthetic examination and evaluation has been performed, the evaluation and management service can be billed using the appropriate patient visit code.

The anesthesiologist must certify on the claim the number of qualified individuals directed concurrently and this requirement is met by use of the appropriate modifier. In addition, the anesthesiologist must have on file each procedure performed and the name of each qualified individual directed. The medical record must clearly indicate whether a case is medically directed or supervised and include the names and signatures of all professionals involved in providing the anesthesia service. Anesthesia time must be indicated as well.

### Modifiers

Effective with this policy change, each claim line billing for anesthesia services, type of service 7, must include one of the modifiers described in the table below. As indicated in the table, the modifier used will generate a calculated fee screen as described under “payment calculation”.

| Modifier | Description   | Payment Rate                       |
|----------|---|------------------------------------|
| AA       | Anesthesia services performed personally by anesthesiologist.   | 100%                               |
| AD       | Medical supervision by a physician: more than four concurrent anesthesia procedures                       | Flat rate of 3 ABUs, no time units |
| QK       | Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals | 50%                                |
| QX       | CRNA service: with medical direction by a physician   | 50%                                |
| QY       | Anesthesiologist medically directs one CRNA   | 50%                                |
| QZ       | CRNA service: (supervised) without medical direction by a physician                                       | 100%                               |

Modifier QS, monitored anesthesia care service, should be used in addition to the modifiers above when MAC is provided and must be reported as the second modifier on the claim line. If QS is used alone, the claim will be rejected.

### Billing Requirement Summary

- Anesthesia services will continue to be billed using the surgical HCPCS (CPT) codes and type of service 7.
- Allowable settings include the inpatient or outpatient hospital setting, and licensed freestanding surgical outpatient facilities (ambulatory surgery center). No general, regional or monitored anesthesia services are payable in the office or other ambulatory settings.

- Time is reported in the quantity field as a "1" for each minute of anesthesia time.
- Base units are automatically considered in the calculation process. Do **not** include ABUs in the quantity field.
- A modifier from the table above must be reported with each type of service 7 service.
- The QS modifier should be reported in addition if MAC was provided.
- Procedure code 01996, daily management of epidural or subarachnoid drug administration, is covered for dates of service on and after May 1, 2001.

### Manual Maintenance

Retain this bulletin for future reference.

### Questions

Any questions regarding this bulletin should be directed to: Provider Inquiry, Medical Services Administration, P.O. Box 30479, Lansing, Michigan 48909-7979, or e-mail at [ProgramSupport@state.mi.us](mailto:ProgramSupport@state.mi.us). Providers may phone toll free 1-800-292-2550.

Approved



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