

Department of Anesthesiology (Jax)

College of Medicine – Jacksonville

Anesthesiology Billing Compliance Plan

Revised October 1, 2015

I. Billing Compliance Administrative Policies and Procedures

1.0 INTRODUCTION

The Department of Anesthesiology has a strong and abiding commitment to ensuring that its billing activities are conducted in accordance with applicable law. The Department recognizes the need to ensure that our physicians and staff are well informed about State and Federal regulations applicable to billing, that we comply with these rules, and that performance is regularly audited so as to strengthen detected weaknesses. This plan is designed to assist in meeting these goals and to provide guidance to the staff of the Department of Anesthesiology.

The Department also recognizes that employees of the University of Florida and the University of Florida Jacksonville Physicians Inc. are integral parts of billing compliance. Therefore, any person who generates anesthesia documentation used for billing, codes or handles the anesthesia documentation, processes the anesthesia bill or reviews the anesthesia documentation for billing or coding purposes is well informed about State and Federal regulations applicable to billing and to this Anesthesiology Billing Compliance Plan.

2.0 REPORTING OF COMPLIANCE CONCERNS

The College of Medicine of the University of Florida is committed to providing an environment of honesty, integrity and trust. If you have concerns about legal or ethical issues speak with your departmental compliance officer or you may call the Billing Compliance and Corporate Responsibility Hotline at 1-877-264-2520.

The Compliance Hotline is a resource for all employees who may be confronted with ethical issues in areas such as Billing Issues, Proper Accounting and Record Keeping, and Relations with Government Officials and Regulatory Agencies.

Anonymous reports are accepted. You may use this number to follow up or learn the results of the investigation process.

3.0 DEPARTMENTAL COMPLIANCE LEADER

The Chair of the Department shall appoint a Departmental Compliance Leader for the Department of Anesthesiology. The Chair of the Department, Office of Compliance, the University of Florida Jacksonville Physicians, Inc. Clinical Data Quality Department (the “CDQ”), and the University of Florida Jacksonville Physicians, Inc Business Groups (the PBG) will

ensure that any new appointment of a Departmental Compliance Leader will receive adequate education and orientation in compliance policies, coding, billing, and compliance monitoring processes. The Departmental Compliance Leader is responsible for actively participating in the COM Compliance Committee, working with the Office of Compliance personnel during the centralized audit process and working as a liaison between the Chair, Committee, Administrators, and the Office of Compliance to enhance and maintain the College of Medicine's billing compliance program (the "Program"). The Program includes procedures such as screening for ineligible persons, regular centralized audits, and general and specific education of College of Medicine employees. The Departmental Compliance Leader is also responsible for ensuring all new anesthesia providers (including residents and student nurse anesthetists (SRNAs)) receive adequate education in the Anesthesiology Billing Compliance Plan.

4.0 EDUCATION ACTIVITIES AND EDUCATION OF NEW EMPLOYEES

Any person who generates anesthesia documentation used for billing, codes or handles the anesthesia documentation, processes the anesthesia bill or reviews the anesthesia documentation for billing or coding purposes is required to be educated to this Anesthesiology Billing Compliance Plan.

The educational activities and the education of all new employees will be conducted in coordination with the Office of Compliance and the CDQ so that such activities may be centrally documented and will meet the requirements of the Program. Additionally, compliance issues may be discussed on an ad hoc basis at department or divisional meetings. Only Compliance, in collaboration with CDQ and the Department of Anesthesia, is permitted to update compliance educational materials. The Departmental Compliance Leader will work with the Office of Compliance to ensure all departmental hires receive training. CDQ and PBG directors will also work with the Office of Compliance to ensure their new hires receive training.

5.0 REVIEW OF BILLING PRACTICES

5.1 Chart Monitoring

5.1.1 The Office of Compliance shall audit 12 encounters per Provider per audit cycle, in accordance with the Program.

5.1.2 The Departmental Compliance Leader will act as a contact person and facilitator within the Department. If requested, the Department will provide space for auditors to work and review documents during the audit process. The Departmental Compliance Leader or his or her designee will review audit outcomes prior to the circulation of audit findings.

5.2 Reporting

Once completed, the Office of Compliance will provide audit results to the Departmental Compliance Leader and the Department Chair. The Office of Compliance also shall maintain a database of audit outcomes.

5.3 Post-Audit Education

The Department of Anesthesiology, CDQ, or PBG is responsible for ensuring that any individual in their respective departments determined to require corrective educational action (as a result of the audit findings) attend educational sessions coordinated with the Office of Compliance and the CDQ Department.

5.4 Discipline

5.4.1 The Department Chair, pursuant to University rules and in consultation with the Office of Compliance, will be responsible for imposing the appropriate remedies and sanctions when compliance problems occur with Providers. The University's existing remedial and disciplinary mechanisms for violations of billing compliance policies and procedures include but are not limited to letters of counseling, letters of reprimand, suspension without pay and termination.

The Director of the Office of Compliance pursuant to University rules and in consultation with General Counsel, UF or University of Florida Jacksonville Healthcare, Inc. Human Resources, and the Anesthesia Department Chair will be responsible for imposing the appropriate remedies and sanctions when compliance problems occur with providers. . The University's existing remedial and disciplinary mechanisms for violations of billing compliance policies and procedures include but are not limited to letters of counseling, letters of reprimand, suspension without pay and termination.

The Directors of the CDQ Department and PBG Department pursuant to rules and in consultation with the Office of Compliance and University of Florida Jacksonville Healthcare, Inc. Human Resources will be responsible for imposing the appropriate remedies and sanctions when compliance problems occur with employees in their respective departments. The practice plan's existing remedial and disciplinary mechanisms for violations of billing compliance policies and procedures include but are not limited to letters of counseling, letters of reprimand, suspension without pay and termination.

5.4.2 A more detailed review of potential compliance violations and probable consequences for physicians and staff can be found in a memorandum entitled "Remedial and Disciplinary Action for Billing Non-Compliance." This memorandum is available for review from the Office of Compliance web site at: <http://www.hscj.ufl.edu/college-of-medicine/compliance>

5.5 Expanded Audits and Refunds

5.5.1 There may be instances when the results of the audit process require that expanded auditing be conducted. Depending upon the size and scope of an expanded audit, the Department may be held financially responsible for the costs of expanded auditing, which will be conducted by the Office of Compliance.

5.5.2 The Office of Compliance will identify overpayments, if any, arising from compliance audit activity (including regular and expanded audits), and track the timeliness of the refund processing by the Billing Refund Analyst. The College of Medicine – Jacksonville Director of

Physician Billing Compliance, in consultation with General Counsel, will determine if any further action needs to be taken or if any disclosure needs to be made.

6.0 REVIEW AND UPDATE OF COMPLIANCE PLAN

This document, as well as other written policies and procedures for billing activities, will be maintained by the Office of Compliance in coordination with the Department, CDQ and PBG. The Anesthesiology Billing Compliance Plan will be reviewed on an annual basis by the Departmental Compliance Leader and the Chair of the Department in order to identify any needed modifications as well as specific compliance objectives during the succeeding year. Documentation of the review will be provided to the Office of Compliance.

In addition, any new information about CMS or other billing compliance changes recognized by the Office of Compliance, CDQ or PBG must be forwarded to the Departmental Compliance Leader and Chair of the Department in a timely manner for a timely review for possible revisions of the Anesthesiology Compliance Plan. Any revision is required to have approval of the Department of Anesthesiology, Office of Compliance, CDQ and PBG.

Any new lines of business or services need to be coordinated with the Office of Compliance, CDQ and PBG to ensure proper billing guidance is provided.

II. Billing Compliance Rules Policy and Procedures

7.0 BILLING FOR SURGICAL ANESTHESIA SERVICES

In general, Teaching Physicians may bill for the supervision of a fellow, resident, intern, certified registered nurse anesthetist ("CRNA"), anesthesiologist assistant ("AA"), or SRNA in one of three ways, depending on the level of supervision and the number of concurrent anesthesia services being provided. Specifically, Teaching Physician participation in surgical anesthesia services can be performed on the three following levels:

- Personal Performance
- Medical Direction
- Medical Supervision

Each of these levels of billing (and the corresponding level of Teaching Physician participation) is outlined in greater detail below.

8.0 PERSONAL PERFORMANCE OF SURGICAL ANESTHESIA SERVICES

8.1 Definition

An anesthesiologists is considered to be personally providing anesthesia services if he/she meets one of the following criteria:

- The physician personally performed the entire anesthesia service alone

- The physician is involved with one anesthesia case with a resident, the physician is a teaching physician (as defined in CMS* Section 100. Also see 8.3)
- 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 (CMS* Section 100.1.4)
- The physician is continuously involved in a single case involving a SRNA
- The physician is continuously involved in one anesthesia case involving a CRNA or AA, then the service is billed in accordance with the medical direction payment policy and NOT personal performance unless the services of each are found to be medically necessary. Documentation must be submitted by both the CRNA/AA and the physician to support payment of the full fee for each of the two providers. The physician reports the -AA modifier and the CRNA/AA reports the -QZ modifier for a non-medically directed case. (Also see 9.4)

NOTE: The Teaching Physician's physical presence during only the pre-operative or post-operative visits with the patient is not sufficient to bill for the services.

8.2 Billing Code Modifiers

When billing for services that are personally performed, the Teaching Physician should use the -AA modifier as the primary modifier. Additional modifiers for MAC (-QS, -G8, -G9), when applicable, are to be submitted in the secondary modifier position. (See 9.7) The -GC modifier (this service has been performed in part by a resident under the direction of a teaching physician) must be submitted whenever a resident or fellow is involved in the service and should be entered as the final modifier (i.e., after the AA and any applicable MAC modifier). (See CMS* 50 B and CMS* 50 K).

8.3 Teaching Physician (See 100.1.2 (4))

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 physician's physical presence during only the pre-operative or postoperative visits with the beneficiary is not sufficient to receive Medicare payment. 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 his or her immediate availability or 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 NPI of the teaching anesthesiologist who started the case must be indicated in the appropriate field on the claim form.

NOTE: The Teaching Physician is not immediately available if he or she is performing services involving other patients except as noted in section 9.2

8.3.1 Acceptable Documentation

When personally performing an anesthesia case, an anesthesiologist does not need to provide extra documentation or attestations to be compliant with CMS or other payors, but since such work is not easily identifiable in our electronic medical record (EMR) and the number of such cases is few, documentation and attestation of medical direction will be required by the EMR software. Likewise, when directing a single case with a resident, the attending anesthesiologist must provide documentation in the medical record that they were present for critical events including induction, emergence and immediately available to be compliant with CMS guidelines. But since the EMR again cannot easily differentiate resident cases, from SRNA cases, from CRNA cases, the Department has decided that all cases require the anesthesiologist to document that he/she or another qualified attending provided the following:

- A pre-anesthesia examination and evaluation
- Prescribed the anesthesia plan
- Personally participated in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence
- Monitored the course of anesthesia administration at frequent intervals
- Remained physically present and available for immediate diagnosis and treatment of emergencies
- Provided indicated post-anesthesia care.
- Another teaching anesthesiologist was available as necessary

8.4 Delineation of Terms

Since CMS defines **Direct Supervision** differently than the ACGME defines **Direct Supervision**, the term **Direct Supervision** will **NOT** be used in this document or in documentation of anesthesia services provided. Instead descriptive phrases will be used to clearly document the type of supervision/direction provided.

Residents are defined as:

- An individual who participates in an approved GME program
- A physician who is not in an approved GME program but who is authorized to practice only in a hospital setting.
- Includes interns and fellows in GME programs recognized as approved for purposes of direct GME payments.
- Status does not change even if hospital includes the physician in its FTE count of residents.

Fellows are a sub-category of resident above and are defined as a physician in an accredited GME program who has completed the requirements for eligibility for first board certification in the specialty (AKA “subspecialty residents”). Fellows who are not part of an accredited GME program are not considered a Resident and must be separately credentialed to bill. Lack of billing credentials does not divert the fellow to the category of resident.

8.5 Surgical Procedures

8.5.1 Surgical Procedures by CRNA/AA

Surgical procedures fall outside of the rules relevant to anesthesia codes (i.e., ASA codes 00XXX). Surgical procedures performed by either a CRNA or AA must be documented by the CRNA or AA and billed under the CRNA or AA NPI number.

When a procedure is performed by a CRNA or an AA, the performing CRNA or AA must sign or attest the procedure note even if the procedure note is documented in the anesthesia record by an anesthesiologist, resident or SRNA.

8.5.2 Surgical Procedures involving Residents/Fellows

When residents/fellows are involved in the performance of a surgical procedure, the supervising/attending physician must ensure that procedures performed by the resident/fellow are warranted, that adequate informed consent has been obtained and that the resident/fellow has an appropriate level of supervision during the procedure to include sedation. The level of supervision (according to the Department of Anesthesiology Supervision Policy) must match both the resident’s/fellow’s ability to determine the appropriateness of the procedure and the resident’s/fellow’s ability to perform the procedure. All required supervision must be documented by the resident/fellow and/or the supervising/attending physician according to Medical Staff rules

Billing requirements for services involving residents/fellows may differ greatly from ACGME requirements. In order to support a billable charge, the teaching physician must satisfy presence and participation requirements and must personally document his or her presence and participation.

8.5.2.1 Minor Procedures involving Residents/Fellows

For procedures that take only a few minutes (five minutes or less) to complete, and involve relatively little decision making once the need for the procedure is determined, the teaching physician must be physically present for the entire procedure in order to bill for the procedure. Medicare categorizes these services as Minor procedures for teaching physician documentation purposes. None of the procedures performed in Anesthesiology meet the criteria for Minor procedures and therefore do not apply.

8.5.2.2 Definition of 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.

8.5.2.3 Acceptable Documentation for personally performed procedures

- *"I personally performed the procedure."*
- *"I was physically present for the entire procedure."*

8.5.3 Procedures involving Residents/Fellows which are not Minor

The teaching anesthesiologist must satisfy each of the following requirements and document each to qualify for payment:

- The teaching anesthesiologist must be present during all critical or key portions of the procedure. (See 8.5.2.2)
- The teaching anesthesiologist must be immediately available to provide anesthesia services during the entire procedure.
- The teaching anesthesiologist must specifically document the critical or key portions of the case.

8.5.3.1 Appropriate Documentation procedures involving Residents/Fellows which are not Minor

The Department of Anesthesiology has decided the following is appropriate:

- *"I was physically present during all the critical or key portions of the procedure which were identification of landmarks, correct procedural technique, and verification and was immediately available for the remainder of the procedure."*

8.6 CRNA/AA Direct Billing

If the anesthesiologist leaves the O.R. for an extended period of time and he or she had been supervising a CRNA/AA, the CRNA/AA may bill directly for the service. The claim form for this service should note clearly that the service was provided by the CRNA/AA and not the anesthesiologist.

8.6.1 Billing Code Modifier

When billing for services that are provided by the CRNA/AA alone and not the anesthesiologist, or when the anesthesiologist is providing only medical supervision of the CRNA/AA, the -QZ modifier will be reported on the CRNA/AA charge.

8.7 Payment for Directing CRNA/AA in Single Case

An anesthesiologist personally performing a single case with a CRNA or AA will split the fee with the CRNA/AA. We are reimbursed 100% fee split in different proportions depending on the carrier.

8.7.1 Billing Code Modifier

When billing for services that are provided by an anesthesiologist personally performing a single case with a CRNA/AA, the -QX modifier will be reported on the CRNA/AA charge.

8.8 No Billing by Resident

If the anesthesiologist leaves the O.R. for an extended period of time and he or she had been supervising a resident or intern, the resident or intern may not bill Medicare directly for the service.

8.9 Post-Anesthesia Notes and Visits

The Teaching Physician Anesthesiologist is not required to perform the pre- or post-anesthesia visit to bill CMS for anesthesia services. The Teaching Anesthesiologists is required to document they provided indicated postoperative care.

8.9.1 Post-Anesthesia Evaluation Note

A post-anesthesia evaluation will be completed and documented by an individual qualified to administer anesthesia no later than 48 hours after surgery or a procedure requiring anesthesia services. The Department has decided that every patient will receive a minimum of one post-anesthesia evaluation note by the attending anesthesiologists which the EMR will require before being allowed to close the case. (See 8.9.2 for documentation details)

The calculation of the 48-hour timeframe begins at the point the patient is moved into the designated recovery area. The evaluation generally should not be performed immediately at the point of movement from the operative area to the designated recovery area. Rather, accepted standards of anesthesia care indicate that the evaluation should not begin until the patient is sufficiently recovered from the acute administration of the anesthesia so as to participate in the evaluation, e.g., answer questions appropriately, perform simple tasks, etc. While the evaluation should begin in the PACU/ICU or other designated recovery location, it may be completed after the patient is moved to another inpatient location or, for same day surgeries, after the patient is discharged, so long as it is completed within 48 hours.

8.9.2 Acceptable Documentation for Post-Anesthesia Evaluation Note.

The elements of an adequate post-anesthesia evaluation should be clearly documented and conform to current standards of anesthesia care, including:

- Respiratory function including respiratory rate, airway patency, and oxygen saturation
- Cardiovascular function including pulse rate and blood pressure

- Mental status
- Temperature
- Pain
- Nausea and vomiting
- Postoperative hydration.

For those patients who are unable to participate in the postanesthesia evaluation (e.g., post-operative sedation, mechanical ventilation, etc.), a postanesthesia evaluation should be completed and documented within 48 hours with notation that the patient was unable to participate.

This CMS requirement for a post-anesthesia evaluation within 48 hours after anesthesia services is separate from the Joint Commission Element of Performance that all patients need to be discharged from the recovery area or from the hospital, and in the absence of a qualified practitioner, patients may be discharged according to approved criteria.

9.0 MEDICAL DIRECTION / CONCURRENT CARE OF SURGICAL ANESTHESIA SERVICES

9.1 Conditions for Medicare Payment

Medicare pays for the anesthesiologist's medical direction of anesthesia services for one, two, three or four concurrent anesthesia services furnished to patients only if the physician for each patient does **ALL** of the following:

- Performs a pre-anesthesia examination and evaluation
- Prescribes the anesthesia plan
- Personally participates in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence
- Ensures that any procedures in the anesthesia plan that the physician does not perform are performed by a qualified individual
- 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

The anesthesiologist **ALONE** must document in the patient's medical record that the conditions set forth above have been satisfied, specifically documenting that he or she performed the pre-anesthetic exam and evaluation, provided the indicated post-anesthesia care, and was present during the most demanding procedures, including induction and emergence where applicable.

If applicable, the medically directing physician participates in emergence if he or she is present and observes the patient's condition any time between the administration of the last medication used to produce or maintain anesthesia until 30 minutes after the patient is left in the care of another healthcare provider in a Post Anesthesia Care Unit or Intensive Care Unit.

9.2 Limited Exception to Concurrency Limits for Short Term Emergencies in Immediate Area

A physician who is concurrently directing the administration of anesthesia to not more than four surgical patients ordinarily cannot be involved in furnishing additional services to other patients. However, the anesthesiologist may address an emergency of short duration in the immediate area while medically directing concurrent surgical cases.

Specific examples of such short-term emergencies include: (1) administering an epidural or caudal anesthetic to ease labor pain; (2) periodic rather than continuous monitoring of an obstetrical patient; (3) receiving patients entering the operating suite for the next surgery; (4) checking or discharging patients in the recovery room; (5) handling scheduling matters; or (6) providing brief guidance to pre-op clinic personnel via telephone from the operating room.

9.3 Billing Code Modifier

When billing for medical direction of concurrent care, the -QK modifier will be reported as the primary modifier for the anesthesiologist charge. Additional modifiers for MAC (-QS, -G8, -G9), when applicable, are to be submitted in the secondary modifier position. (See 9.7) The -GC modifier (this service has been performed in part by a resident under the direction of a teaching physician) must be submitted whenever a resident or fellow is involved in the service and should be entered as the final modifier (i.e., after the AA and any applicable MAC modifier). (See CMS* 50 B and CMS* 50 K).

9.4 Reduced Number of Concurrent Cases for SRNA

The medical direction rules apply to cases involving SRNAs if the physician directs two concurrent cases, each of which involves a SRNA, or the physician directs one case involving a SRNA and another involving a CRNA, AA, or resident. If the anesthesiologist is medically directing a SRNA, the maximum number of concurrent cases that may be medically directed is two (2). The anesthesiologist may only receive 50% of Medicare allowed amount for each case.

9.4.1 Billing Code Modifier

When billing for medical direction of a SRNA, the -QK modifier will be reported as the primary modifier for the anesthesiologist charge. Additional modifiers for MAC (-QS, -G8, -G9), when applicable, are to be submitted in the secondary modifier position. (See 9.7)

9.5 Rules Applicable If Even One Concurrent Case Is Medicare

Concurrency does not require each of the cases to involve a Medicare patient. For example, if an anesthesiologist directs three concurrent procedures, two of which involve non-Medicare patients and the remaining involves a Medicare patient, this represents three concurrent cases.

9.6 Reimbursement Effect of Failing to Meet Concurrency Requirements

If the concurrency limits are exceeded, or if the anesthesiologist leaves the immediate area of the operating suite for other than a short duration or devotes extensive time to an emergency case or is otherwise not available to respond to the immediate needs of the surgical patients, the anesthesiologist's services to all of the surgical patients become *supervisory* in nature and do not meet the criteria for medical direction. Medicare payments would be reduced from the concurrency rates for medical direction for the surgical cases to the supervisory rates described below in section 10.

9.7 Monitored Anesthesia Care (See LCD 32628).

Coverage for MAC is allowed if the anesthesia service is medically reasonable and necessary and if the procedure for which MAC is given is itself a Medicare benefit and is medically reasonable and necessary.

9.7.1. Personnel

In keeping with the American Society of Anesthesiologists' standards for monitoring, MAC should be provided by qualified anesthesia personnel, (anesthesiologists or qualified anesthetists such as CRNAs or AAs). These individuals must be continuously present to monitor the patient and provide anesthesia care. Residents under the supervision of an anesthesiologist are qualified anesthesia persons.

9.7.2. Monitoring

During MAC, the patient's oxygenation, ventilation, circulation and temperature should be evaluated by whatever method is deemed most suitable by the attending anesthetist. 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.

9.7.3. General Requirements

The following CMS requirements for this type of anesthesia should be the same as for general anesthesia with regards to the performance of pre-anesthetic examination and evaluation, prescription of the anesthesia care required, the completion of an anesthesia record, the administration of necessary oral or parenteral medications and the provision of indicated post-operative anesthesia care. Appropriate documentation must be available to reflect pre and post-anesthetic evaluations and intraoperative monitoring.

NOTE: Any case scheduled for MAC where (for even a brief period) the patient would qualify as receiving General Anesthesia, the whole case should be considered a General Anesthetic.

9.7.4. Medical Necessity

The MAC service rendered must be appropriate and medically reasonable and necessary. Anesthesia procedures usually provided by the attending surgeon 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. This is true if there are one or more of the co-existing conditions present. In this situation, the appropriate MAC modifier is –QS.

The MAC modifier G8 indicates that the surgical procedure is deep, complex, complicated or markedly invasive AND includes only procedures on the face (00100 and 00160 and NOT eyes); head, neck, and posterior trunk (00300); breast (00400), or genitalia (00920) and for access to the central venous circulation (00532). (See LCD 32628 for the complete list). These CPT codes themselves do not differentiate complexity.

The MAC modifier G9 is used with an anesthesia code to indicate that the patient has a history of a severe cardiopulmonary condition.

Anesthesia codes utilized to indicate 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 – premonitory condition with high risk of demise unless procedural intervention is performed.

In summary, MAC may be necessary and justified for the CPT/HCPCS procedures with the -QS modifier if a co-existing condition exists, or if the procedure qualifies for a -G8 or -G9 modifier. Regardless of which indication (-QS, G8 or G9) is identified, there must be adequate documentation in the preoperative evaluation to support medical necessity and that code.

9.7.5. Reimbursement

Reimbursement for MAC will be the same amount allowed for full general anesthesia services if all the requirements listed under these indications are met. No additional reimbursement is allowed with the use of modifiers (e.g., -QS, -G8, -G9). 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.

9.7.6. General Note of Caution

The presence of an underlying condition alone, as reported by an ICD-9-CM code, may not be sufficient evidence that MAC is necessary. The medical condition must be significant enough to impact 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.

9.7.7 Appropriate Documentation

The Department of Anesthesiology has decided due to lack of specific CMS direction and Florida Medicare Administrative Contractor direction and in consultation with **LCD 32628**, the following documentation is appropriate. (*The top six indications for MAC are listed for the -QS modifier to be used. The indication should be supported in the preoperative evaluation*)

- "An anxiety disorder which will not allow the procedure to be safely performed without anesthesia provided by a member of the anesthesia team" (*Generates a -QS modifier*)
- "A psychiatric disorder which will not allow the procedure to be safely performed without anesthesia provided by a member of the anesthesia team" (*Generates a -QS modifier*)
- "A neurologic disorder which will not allow the procedure to be safely performed without anesthesia provided by a member of the anesthesia team" (*Generates a -QS modifier*)
- "A pain disorder which will not allow the procedure to be safely performed without anesthesia provided by a member of the anesthesia team" (*Generates a -QS modifier*)
- "Morbid obesity (BMI >40)" (*Generates a -QS modifier*)
- "Other: Please free text" (*See LCD 32628 for the complete list*) (*Generates a -QS modifier*)
- "The surgical procedure is deep, complex, complicated or markedly invasive one on the face (NOT eyes); head, neck, and posterior trunk; breast, or genitalia and for access to the central venous circulation." (*See LCD 32628 for the complete list*) (*Generates a -G8 modifier*)
- "The patient has a history of a severe cardiopulmonary condition." (*Generates a -G9 modifier*)

10.0 MEDICAL SUPERVISION OF SURGICAL ANESTHESIA SERVICES

10.1 Definition

If the anesthesiologist is involved in more than four concurrent procedures or is performing other services (not listed in the exceptions under 9.2) while directing the concurrent procedures, the anesthesiologist should bill only for medical supervision of the surgical cases.

10.2 Billing Code Modifier

When billing for medical supervision, the anesthesiologist should use the -AD modifier.

10.3 Reimbursement

Payment for medical supervision consists of three base units per procedure and one time unit. An additional time unit may be reported if the anesthesiologist documents that he or she was present at induction.

11.0 Qualified Nonphysician Anesthetist Services (See CMS* 140)

Section 9320 of OBRA 1986 provides for payment under a fee schedule to certified registered nurse anesthetists (CRNAs) and anesthesia assistants (AAs). CRNAs and AAs may bill Medicare directly for their services or have payment made to an employer or an entity under which they have a contract.

Anesthesia services are subject to the usual Part B coinsurance and deductible and when furnished by a qualified nonphysician anesthetist are paid at the lesser of the actual charge, the physician fee schedule, or the anesthesia fee schedule. Payment for qualified nonphysician anesthetist services is made only on an assignment basis.

11.1 Qualified Nonphysician Anesthetists (See CMS* 140.1)

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.

11.2 Entity or Individual to Whom Fee Schedule is Payable for Qualified Nonphysician Anesthetists (See CMS* 140.2)

Payment for the services of a qualified nonphysician anesthetist may be made to the qualified nonphysician anesthetist who furnished the anesthesia services or to a hospital, physician, group practice, or ASC with which the qualified nonphysician anesthetist has an employment or contractual relationship.

11.3 Anesthesia Time and Calculation of Anesthesia Time Units (See CMS*140.3.2)

Anesthesia time means the time during which a qualified nonphysician anesthetist is present with the patient. It starts when the qualified nonphysician anesthetist begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ends when the qualified nonphysician anesthetist is no longer furnishing anesthesia services to the patient, that is, when the patient may be placed safely under postoperative care. Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service. In counting anesthesia time for services furnished, the qualified nonphysician anesthetist can add blocks of time around

an interruption in anesthesia time as long as the qualified nonphysician anesthetist is furnishing continuous anesthesia care within the time periods around the interruption.

Billable time associated with the CRNA/AA charge must be adjusted when a CRNA/AA leaves the operating room. Only the time when the CRNA/AA was physically present in the operating room may be reported.

11.4 Billing Modifiers (See CMS* 140.3.3)

The following modifiers are used when billing for anesthesia services:

- QX - Qualified nonphysician anesthetist with medical direction by a physician.
- QZ - CRNA without medical direction by a physician.
- QS - MAC can be billed by a qualified nonphysician anesthetist or a physician).
- G8 - MAC modifier G8 indicates that the surgical procedure is deep, complex, complicated or markedly invasive AND includes only procedures on the face (00100 and 00160 and NOT eyes); head, neck, and posterior trunk (00300); breast (00400), or genitalia (00920) and for access to the central venous circulation (00532). (See LCD 32628 for the complete list).
- G9 - MAC modifier G9 is used with an anesthesia code to indicate that the patient has a history of a severe cardiopulmonary condition.
- QY - Medical direction of one qualified nonphysician anesthetist by an anesthesiologist. This modifier is effective for anesthesia services furnished by a qualified nonphysician anesthetist.

11.5 General Billing Instructions (See CMS* 140.3.4)

Claims for reimbursement for qualified nonphysician anesthetist services should be completed in accord with existing billing instructions for anesthesiologists with the following additions.

- If an employer-physician furnishes concurrent medical direction for a procedure involving CRNAs and the medical direction service is unassigned, the physician should bill on an assigned basis on a separate claim for the qualified nonphysician anesthetist service. If the physician is participating or takes assignment, both services should be billed on one claim but as separate line items.
- All claims forms must have the provider billing number of the CRNA, AA and/or the employer of the qualified nonphysician anesthetist performing the service in either block 24.H of the Form CMS-1500 and/or block 31 as applicable. Verify that the billing number is valid before making payment.

Payments should be calculated in accordance with Medicare payment rules in CMS* 140.3. Contractors must institute all necessary payment edits to assure that duplicate payments are not made to physicians for CRNA or AA services or to a CRNA or AA directly for bills submitted on their behalf by qualified billers.

CRNAs are identified on the provider file by specialty code 43. AAs are identified on the provider file by specialty code 32.

11.6- Payment for Anesthesia Services Furnished by a Teaching CRNA (See CMS* 140.5)

Payment can be made under Part B to a teaching CRNA who supervises a single case involving a SRNA where the CRNA is continuously present. The CRNA reports the service using the usual -QZ modifier. This modifier designates that the teaching CRNA is not medically directed by an anesthesiologist. No payment is made under Part B for the service provided by a SRNA.

The American Association of Nurse Anesthetists (AANA) indicates that their standards for approved nurse anesthetist training programs allow teaching CRNAs to supervise two concurrent cases involving SRNAs. You may allow payment, as follows, if a teaching CRNA is involved with two SRNAs:

- Recognize the full base units (assigned to the anesthesia code) where the teaching CRNA is present with the SRNA throughout pre and post anesthesia care; and
- Recognize the actual time the teaching CRNA is personally present with the SRNA. Anesthesia time may be discontinuous. For example, a teaching CRNA is involved in two concurrent cases with SRNAs. Case 1 runs from 9:00 a.m. to 11:00 a.m. and case 2 runs from 9:45 a.m. to 11:30 a.m. The teaching CRNA is present in case 1 from 9:00 a.m. to 9:30 a.m. and from 10:15 a.m. to 10:30 a.m.. From 9:45 a.m. to 10:14 a.m. and from 10:31 a.m. to 11:30 a.m., the CRNA is present in case 2. The CRNA may report 45 minutes of anesthesia time for case 1 (i.e., 3 time units) and 88 minutes (i.e., 5.9 units) of anesthesia time for case 2.

The teaching CRNA must document his/her involvement in cases with SRNAs. The documentation must be sufficient to support the payment of the fee and available for review upon request.

The teaching CRNA, not under the medical direction of a physician, can be paid for his/her involvement in each of two concurrent cases with SRNAs. Allow payment at the regular fee schedule rate if the teaching CRNA is involved with two concurrent SRNA cases. The CRNA reports the anesthesia service using the -QZ modifier.

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

To bill anesthesia time for each case, the teaching CRNA must continue to devote his/her time to the two concurrent cases and not be involved in other activities. The teaching CRNA can decide how to allocate his or her time to optimize patient care in the two cases based on the complexity of the anesthesia case, the experience and skills of the SRNA, the patient's health status and other factors.

The teaching CRNA must document his/her involvement in the cases with the SRNAs.

12.0 INPATIENT VISITS

Inpatients are followed by members of the Department of Anesthesiology. While most inpatients are in the Intensive Care and Intermediate Care Units, other patients may receive care on other inpatient units. Teaching Physicians must adhere to the general rules for E/M services outlined in Section 4.0 of the global Teaching Physician Billing Policy. The -GC modifier must be reported to designate instances when residents or fellows are involved in the care of the patient.

13.0 OFFICE OR OUTPATIENT

Outpatient medical care of patients by anesthesia providers is provided in the Preadmission Testing Clinic, Pain Management Clinic, Palliative Care Service, Sleep Medicine Service, and Hyperbaric Medicine Service. Teaching Physicians must follow the general rules for E/M services outlined in Section 4.0 of the global Teaching Physician Billing Policy. All criteria of the clinic visit must be fulfilled to justify the charge submitted. The –GC modifier must be reported to designate instances when residents or fellows are involved in the care of the patient.

For nonphysician practitioners in office or other non-hospital settings (non-OR), refer to section 9.0 of the UF COM – Jacksonville Teaching Physician Billing Policy and Compliance Policy # 2011-05-001 – Medicare Incident to Billing in Physician-Based Settings.

13.1 Preadmission Testing Clinic

Patients may be seen in the Preadmission Testing Clinic for routine preoperative visits or as consultations.

13.1.1 Billable Services

UF Health Jacksonville hospital employs individuals (hereinafter "Preadmission Testing Clinic Providers") who perform directed preanesthetic interviews and examinations for the purpose of optimizing preanesthetic evaluation. No professional fees shall be charged for these evaluations. These evaluations will be reviewed by faculty of the Department of Anesthesiology for the purpose of supervision, to improve patient care, and to further the education and performance of the Preadmission Testing Clinic Providers. Although not separately billable from an anesthesia service, if the anesthesia case is cancelled, it may be possible to bill an E/M visit if all of the components of a billable E/M service are satisfied. (See 14.0)

13.2 Monitored Anesthesia Care in the Office Setting

Monitored anesthesia care (MAC) is a specific anesthetic service for a diagnostic or therapeutic procedure. MAC used with certain interventional pain management procedures (CPT codes 20550, 20551, 20552, 20553, 27096, 62310, 62311, 64479, 64480, 64483, 64484, 64490, 64491, 64492, 64493, 64494 and 64495) where current practice supports that local anesthesia alone, inclusive of these procedures, is typical. For certain patients, the addition of mild sedation (physician service not separately payable) or moderate (conscious) sedation (CPT codes 99143-99150), may be part of these minimally invasive procedures.

MAC may be considered medically necessary, based on the nature of the procedure, the patient's clinical condition and/or the potential need to convert the patient from MAC to a general or regional anesthetic. MAC includes all aspects of general anesthesia care (pre-procedure through postprocedure), which includes:

During MAC, the anesthesiologist or qualified anesthesia provider renders a number of specific services including but not limited to the following:

- Administration of sedatives, analgesics, hypnotics, anesthetic agents or other medications as necessary for patient safety.
- Psychological support and physical comfort.
- Provision of other medical services as needed to complete the procedure safely.

Monitored anesthesia care often includes the administration of doses of medications for which the loss of normal protective reflexes or loss of consciousness is likely. If the patient is rendered unconscious and/or loses normal protective reflexes, the anesthesia care is considered a general anesthetic.

13.2.1 Indications

Monitored anesthesia care will be considered medically reasonable and necessary when the patient's condition requires the presence of a second physician represented by an anesthesiologist or qualified anesthesia provider in addition to the provider performing the procedure. This is true for MAC performed anywhere and for any procedure.. The patient's medical condition or nature of the procedure must require the presence of a second physician represented by an anesthesiologist or qualified anesthesia provider to administer the sedation if utilized, to manage the airway & vital signs, and to continually assess the patient for clinical problems and treat appropriately to ensure patient safety and comfort. The presence of an underlying condition alone or a stable treatable condition is not sufficient evidence that monitored anesthesia care is medically reasonable and necessary.

Monitored anesthesia care for interventional pain management services will be considered medically reasonable and necessary when the following criteria are met:

- Co-morbidities that would require the services of an anesthesiologist or qualified anesthesia provider such as pulmonary disease, cardiac disease, and/or psychiatric conditions with accompanying active symptoms necessitating close monitoring during the procedure, morbid obesity, severe sleep apnea, inability to follow simple commands (i.e., cognitive dysfunction with the inability to perform ADLs and provide self care, dementia or developmental delay), spasticity disorders that would make it difficult for the patient to lie still on the table, or any other co-morbidities that would support the need for the constant presence of an anesthesiologist or qualified anesthesia provider (ASA 3 or ASA 4),
- Severe patient anxiety immediately prior to a procedure which may affect patient safety and comfort.
- Anticipated complexity to the planned standard procedures.

- Complications arising during the planned procedure or the inability to complete attempted interventional pain procedure in a patient who has received sufficient amounts of medications to induce minimal sedation.
- Eligible pediatric patients.

14.0 CONSULTATIONS (INPATIENT & OUTPATIENT)

Patients seen on a consulting basis may be seen by appropriate members of the Department of Anesthesiology. As with any other E/M service, the Teaching Physician should follow the general rules for E/M services outlined in section 5 of the global Teaching Physician Billing Policy.

Medicare does not reimburse consultation codes 99241-99245 and 99251-99255. For specific instructions on billing for consultative services and replacement codes, refer to the following Compliance Policies:

- Selecting a Consultation Replacement Code When Medicare is the Primary Payor – (Compliance Policy # 2009-12-001)
- Consultation Payment Policy - Skilled Nursing Facility or Nursing Facility Location When Medicare is the Primary Payor – (Compliance Policy # 2010-01-002)
- Billing Medicare as the Secondary Payor for Consultation Services (Compliance Policy # 2010-02-001).

15.0 TIME BASED BILLING

Refer to Section 7.0 of the global Teaching Physician Billing Policy for time-based services other than critical care.

16.0 CRITICAL CARE

Refer to Section 8.0 of the global Teaching Physician Billing Policy for Critical Care Services.

17.0 DOCUMENTATION AIDS

Forms and electronic documentation aids require the approval of the Anesthesiology Compliance Leader, the Office of Compliance, and the CDQ before they are implemented. Any new approval will require the education of every anesthesia provider.

CMS* = Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners, (Rev. 3096, 10-17-14)

REFERENCES

1. Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners, (Rev. 3096, 10-17-14)
2. Local Coverage Determination for Monitored Anesthesia Care (MAC) (L 32628)
3. Local Coverage Determination (LCD): MONITORED ANESTHESIA CARE (MAC) for Certain Interventional Pain Management Services (L30561)
4. UF COM Billing Compliance Plan Adobe PDF File (05/2008)
5. UF Teaching Physician Billing Policy Adobe PDF File (08/2011-rev 10.05.11).
6. University Of Florida College Of Medicine Jacksonville Department Of Anesthesiology Resident Supervision Policy
7. Guidelines for Teaching Physicians, Interns, and Residents ICN 006347 February 2015
8. ACGME/CMS Comparison Chart – Resident Supervision.