CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2268	**Date: August 1, 2011**
	Change Request 7465

SUBJECT: Anesthesiologist Services in a Method II Critical Access Hospital (CAH)

I. SUMMARY OF CHANGES: This instruction clarifies the payment calculation for anesthesia services performed by an Anesthesiologist.

EFFECTIVE DATE: January 1, 2008
IMPLEMENTATION DATE: January 3, 2012

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	4/250.3.2/Physician Rendering Anesthesia in a Hospital Outpatient Setting

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
Business Requirements
Manual Instruction
**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2268	Date: August 1, 2011	Change Request: 7465

SUBJECT: Anesthesiologist Services in a Method II Critical Access Hospital (CAH)

Effective Date: January 1, 2008
Implementation Date: January 3, 2012

I. GENERAL INFORMATION

A. Background: Anesthesiologists rendering services in a Method II CAH (also referred to as CAHs that have elected the optional method) have the option of reassigning their billing rights to the CAH. When billing rights are reassigned, the Method II CAH submits an 85x bill type with revenue code 0963 (professional fees for Anesthesiologist (MD)) for payment of the anesthesia services.

Payment is currently being calculated for anesthesia services performed by an Anesthesiologist with a modifier of AA in a Method II CAH on a 20 percent reduction of the fee schedule amount before deductible and coinsurance are calculated. This change request removes the 20% reduction that should not be applied in the payment calculation for these services.

B. Policy : Section 1834 (g)(2)(B) of the Social Security Act (the Act) states that professional services included within outpatient CAH services shall be paid 115 percent of such amounts as would otherwise be paid under this part if such services were not included in the outpatient CAH services.

II. BUSINESS REQUIREMENTS TABLE

Use"Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7465.1	For dates of services on or after January 1, 2008, contractors shall pay for anesthesia services (CPT codes 00100 through 01999) submitted by a Method II CAH on an 85X bill type with revenue code of 963 and modifier AA based on the lesser of the actual charges or the fee schedule amount as follows: (Sum of base units plus time (anesthesia time divided by 15)) times conversion factor minus deductible times 0.80 times 1.15						X				
7465.2	Contractors shall not search for and adjust claims that have been paid prior to the implementation date. However, contractors shall adjust claims brought to their attention.	X		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7465.3	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly. .	X		X							

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below: N/A

Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Cindy Pitts at Cindy.Pitts@cms.hhs.gov or Jason Kerr at Jason.Kerr@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):*

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

250.3.2 – Physician Rendering Anesthesia in a Hospital Outpatient Setting

(Rev.2268, Issued: Effective: 01-01-08, Implementation: 01-03-12)

When a medically necessary anesthesia service is furnished within a HPSA area by a physician, a HPSA bonus is payable. In addition to using the PC/TC indicator on the CORF extract of the MPFS Summary File to identify HPSA services, pay physicians the HPSA bonus when CPT codes 00100 through 01999 are billed with the following modifiers: QY, QK, AA, or GC and "QB" or "QU" in revenue code 963. Modifier QB or QU must be submitted to receive payment of the HPSA bonus for claims with dates of service prior to January 01, 2006. Effective for claims with dates of service on or after January 01, 2006, the modifier AQ, physician providing a service in a health professional shortage area, may be required to receive the HPSA bonus. Refer to §250.2.2 of this chapter for more information on when modifier AQ is required.

The modifiers signify that a physician performed an anesthesia service. Using the Anesthesia File (See Section above) the physician service will be 115 percent times the payment amount to be paid to a CAH on Method II payment plus 10 percent HPSA bonus payment.

Anesthesiology modifiers:

AA = anesthesia services performed personally by anesthesiologist.

GC =service performed, in part, by a resident under the direction of a teaching physician.

QK = medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals.

QY = medical direction of one CRNA by an anesthesiologist.

Modifier AA results in physician payment at 100% of the allowed amount.
Modifier GC result*s* in physician payment at 80% of the allowed amount.
Modifiers QK and QY result in physician payment at 50% of the allowed amount.

Data elements needed to calculate payment:

- HCPCS plus Modifier,
- Base Units,
- Time units, based on standard 15 minute intervals,
- Locality specific anesthesia Conversion factor, and
- Allowed amount minus applicable deductions and coinsurance amount.

Formula 1: Calculate payment for a physician performing anesthesia alone

HCPCS = xxxxx
Modifier = AA
Base Units = 4
Anesthesia Time is 60 minutes. Anesthesia time units = 4 (60/15)

Sum of Base Units plus Time Units = 4 + 4 = 8

Locality specific Anesthesia conversion factor = $17.00 (varies by localities)

Coinsurance = 20%

Example 1: Physician personally performs the anesthesia case

Base Units plus time units - 4+4=8

Total units multiplied by the anesthesia conversion factor times .80

8 x $17= ($136.00 – (deductible*)) x .80 = $108.80

Payment amount times 115 percent for the CAH method II payment.

$108.80 x 1.15 = $125.12 (Payment amount)

$125.12 x .10 = $12.51 (HPSA bonus payment)

*Assume the Part B deductible has already been met for the calendar year

Formula 2: Calculate the payment for the physician's medical direction service when the physician directs two concurrent cases involving CRNAs. The medical direction allowance is 50% of the allowance for the anesthesia service personally performed by the physician.

HCPCS = xxxxx

Modifier = QK

Base Units = 4

Time Units 60/15=4

Sum of base units plus time units = 8

Locality specific anesthesia conversion factor = $17(varies by localities)

Coinsurance = 20 %

(Allowed amount adjusted for applicable deductions and coinsurance and to reflect payment percentage for medical direction).

Example 2: Physician medically directs two concurrent cases involving CRNAs

Base units plus time - 4+4=8

Total units multiplied by the anesthesia conversion factor times .50 equal allowed amount minus any remaining deductible

8 x $17 = $136 x .50 = $68.00 – (deductible*) = $68.00

Allowed amount Times 80 percent times 1.15

$68.00 x .80 = $54.40 x 1.15 = 62.56 (Payment amount)

$62.56 x .10 = $6.26 (HPSA bonus payment)

*Assume the deductible has already been met for the calendar year.