CMS Transmittals: Daily Document Update, Medicare Claims Processing Manual, 100-04, Trans. No. 2634, January 11, 2013—Internet Only Manual (IOM) Update to Payment for Medical or Surgical Services Furnished by CRNAs. This CR rescinds and fully replaces CR 8027, (Jan. 15, 2013)

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CMS Manual System

Pub 100-04 Medicare Claims Processing

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Transmittal 2634

Date: January 11, 2013

Change Request 8180

SUBJECT: Internet Only Manual (IOM) Update to Payment for Medical or Surgical Services Furnished by CRNAs. This CR rescinds and fully replaces CR 8027.

I. SUMMARY OF CHANGES: This CR clarifies existing manual language to bring the manual in line with our revision to our regulations at 410.69.

EFFECTIVE DATE: January 1, 2013

IMPLEMENTATION DATE: February 12, 2013

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	12/140/ Qualified Nonphysician Anesthetist Services
R	12/140.1 - Qualified Nonphysician Anesthetists
D	140.1.1 - Issuance of UPINs
D	140.1.2 - Annual Review of CRNA Certifications
R	12/140.2 - Entity or Individual to Whom Fee Schedule is Payable for Qualified Nonphysician anesthetists
R	12/140.3 - Anesthesia Fee Schedule Payment for Qualified Nonphysician Anesthetists
R	12/140.3.1 - Conversion Factors Used on or After January 1, 1997 for Qualified Nonphysician Anesthetists
R	12/140.3.2 - Anesthesia Time and Calculation of Anesthesia Time Units
R	12/140.3.3 - Billing Modifiers
R	12/140.3.4 - General Billing Instructions
R	12/140.4 - Qualified Nonphysician Anesthetist Special Billing and Payment Situations

R	12/140.4.1 - An Anesthesiologist and Qualified Nonphysician Anesthetist Work Together
R	12/140.4.2 - Qualified Nonphysician Anesthetist and an Anesthesiologist in a Single Anesthesia Procedure
R	12/140.4.3/ - Payment for Medical or Surgical Services Furnished by CRNAs
R	12/140.4.4 - Conversion Factors for Anesthesia Services of Qualified Nonphysician Anesthetists Furnished on or After January 1, 1992

III. FUNDING:

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

Not Applicable

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 obliged 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: 2634 Date: January 11, 2013 Change Request: 8180

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EFFECTIVE DATE: January 1, 2013

IMPLEMENTATION DATE: February 12, 2013

I. GENERAL INFORMATION

A. Background: The purpose of this CR is to clarify existing manual language to bring the manual in line with our revision to our regulations at 410.69.

B. Policy: This revision represents a change in the policy of Medical or Surgical Services Furnished by CRNAs.

II. BUSINESS REQUIREMENTS TABLE
Use "Shall" to denote a mandatory requirement.

Number	Requirement	Responsibility						
		A/B	D M E	F I	C A R R	R H H I	Shared-System Maintainers	Other

		M A C P a r t A	M A C P a r t B	I E R	F I S S	M C S	V M S	C W F S
8180.1	Contractors shall note the change to Pub 100-04, Medicare Claims Processing Manual, Chapter 12, Section 140.		X	X				
8180.2	Contractors need not search their files to either retract payment for claims already paid or to retroactively pay claims. However, contractors shall adjust claims brought to their attention.		X	X				

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC P a r t A	A/B MAC P a r t B	D M E M A C	F I S S	C A R R I E R	R H H I	Other
	None							

IV. SUPPORTING INFORMATION
Section A: Recommendations and supporting information associated with listed requirements: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Chava Sheffield, Chava.Sheffield@cms.hhs.gov, Kathy Bryant, Kathy.Bryant@cms.hhs.gov

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

VI. FUNDING

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

Not Applicable

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 do 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.

140 - *Qualified Nonphysician* Anesthetist Services

(Rev.2634, Issued: 01-11-13, Effective: 01-01-13, Implementation: 02-12-13)

B3-16003, B3-16003 A, B3-3040.4, B3-4172

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. This could be a hospital, physician or ASC. This provision is effective for services rendered on or after January 1, 1989. Anesthesia services are subject to the usual Part B coinsurance and deductible and when furnished on or after January 1, 1992 by a qualified *nonphysician* anesthetist are paid at the lesser of the actual charge, the physician fee schedule, or the CRNA fee schedule. *For services furnished after January 1, 1996, when separate conversion factors for CRNAs were eliminated, anesthesia services 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

140.1 - Qualified *Nonphysician* Anesthetists

(Rev.2634, Issued: 01-11-13, Effective: 01-01-13, Implementation: 02-12-13)

B3-16003.B, B3-4172.1

For payment purposes, qualified *nonphysician* anesthetists *include both CRNAs* and AAs. Thus, the term *qualified nonphysician anesthetist* will be used to refer to both *CRNAs and AAs* unless it is necessary to separately discuss these provider groups.

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.

In contrast, 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.

140.1.1 - Issuance of UPINs

- The CMS will provide a current list of all CRNAs in the carrier State who are certified by the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists. Carriers will check this list of certified CRNAs to document and confirm that applicants are properly qualified. When the applicant begins to bill, the carrier will provide written notice that continued billing privileges are dependent upon continued certification. However, effective August 1, 2005, CMS will discontinue sending the Biannual Recertification list for CRNAs to carriers.
- An employer of a group of CRNAs, e.g., a hospital, physician, or ASC may apply for a single PIN to cover all of the certified CRNAs in their employ. At the time of application, the employer must send a list of the names of all CRNAs for whom billing will be submitted. Carriers must then verify the certification status of the individuals on the list submitted by the employer. Carriers provide written notice to the employer of the names of the CRNAs it may bill for and require a statement from the employer certifying that it will bill only for those CRNAs who have been determined to be properly qualified. The employer must also agree to notify the carrier immediately if a CRNA leaves its employ or to seek authorization to bill for a new CRNA employee.
- In the event an applicant for a billing number is not on the certification list provided by CMS, a notarized copy of the applicant's certification card issued by either of the Councils discussed above can be accepted. This may be necessary in situations where a CRNA has recently moved to a different State. The CMS will also provide carriers with a list of AAs eligible under this provision. The carrier must check this list to verify the presence of the applicant's name before issuing a billing number. In the event the applicant's name is not on this list, the carrier requires a notarized copy of the individual's diploma and other information deemed pertinent in order to verify the applicant's status.

140.1.2 - Annual Review of CRNA Certifications

- Carriers will review their files in November of each year to determine that the credentials of each CRNA continue to be valid. The CMS will provide an updated list of certified CRNAs each October. However, effective August 1, 2005 CMS will discontinue sending the Biannual Recertification list for CRNAs to carriers. The CRNA recertification list was instituted prior to current enrollment procedures and is no longer deemed necessary. CMS requires contractors to verify a CRNA's qualifications when he or she first enrolls in Medicare. With respect to recertification, CRNA's typically only need to submit a recertification application and accompanying fee to the State. No recertification testing is required, thus greatly reducing the need for the ongoing review of a CRNA's credentials. In addition, since no other specialty has a similar biannual recertification list, CRNA's will now be handled the same as any other specialty so as to ensure uniformity.
- The billing privileges of any CRNA or qualified biller will be terminated if the CRNA's certification has expired or otherwise been terminated by the certifying councils. Carriers will provide advance written notice to the CRNA (and employer) of any such decision and provide for a review of the action if requested to do so.

140.2 - Entity or Individual to Whom Fee Schedule is Payable *for Qualified Nonphysician anesthetists*

(Rev.2634, Issued: 01-11-13, Effective: 01-01-13, Implementation: 02-12-13)

B3-16003.C, B3-4830.A

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.

140.3 - *Anesthesia* Fee Schedule Payment *for Qualified Nonphysician Anesthetists*

(Rev.2634, Issued: 01-11-13, Effective: 01-01-13, Implementation: 02-12-13)

B3-16003 D and E

Pay for the services of a *qualified nonphysician anesthetist* only on an assignment basis. The assignment agreed to by the *qualified nonphysician anesthetist* is binding upon any other person or entity claiming payment for the service. Except for deductible and coinsurance amounts, any person who knowingly and willfully presents or causes to be presented to a Medicare beneficiary a bill or request for payment for services of a *qualified nonphysician anesthetist* for which payment may be made on an assignment-related basis is subject to civil monetary penalties.

Services furnished by *qualified nonphysician anesthetists* are subject to the Part B deductible and coinsurance. If the Part B deductible has been satisfied, the fee schedule for anesthesia services *prior to January 1, 1996,* is the least of 80 percent of:

- The actual charge;
- The applicable CRNA conversion factor multiplied by the sum of allowable base and time units; or
- The applicable locality participating anesthesiologist's conversion factor multiplied by the sum of allowable base and time units.

For services furnished on or after January 1, 1996, the fee schedule for anesthesia services furnished by qualified nonphysician anesthetists is the least of 80 percent of:

- *The actual charge;*
- *The applicable locality anesthesia conversion factor multiplied by the sum of allowable base and time units.*

140.3.1 -Conversion Factors Used on or After January 1, 1997 *for Qualified Nonphysician Anesthetists*

(Rev.2634, Issued: 01-11-13, Effective: 01-01-13, Implementation: 02-12-13)

B3-16003.F

The conversion factors applicable to anesthesia services furnished on or after January 1, 1997, are increased by the update factor used to update physicians' services under the physician fee schedule. They are published in November of the year preceding the year in which they apply.

140.3.2 - Anesthesia Time and Calculation of Anesthesia Time Units

(Rev.2634, Issued: 01-11-13, Effective: 01-01-13, Implementation: 02-12-13)

B3-15018.G

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 on or after January 1, 2000, 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.

140.3.3 - Billing Modifiers

(Rev.2634, Issued: 01-11-13, Effective: 01-01-13, Implementation: 02-12-13)

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 - Monitored anesthesiology care services (can be billed by a *qualified nonphysician anesthetist* or a physician).
- QY - Medical direction of one *qualified nonphysician anesthetist* by an anesthesiologist. This modifier is effective for anesthesia services furnished by a *qualified nonphysician anesthetist* on or after January 1, 1998.

140.3.4 - General Billing Instructions

(Rev.2634, Issued: 01-11-13, Effective: 01-01-13, Implementation: 02-12-13)

B3-4172.5

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

- All claim forms must include the following certification, as applicable

  “CRNA or AA services have been medically directed,” (indicate “A” in field 41, location l05 of Claim Detail l on an EMC bill), or; “CRNA or AA services have not been medically directed,” (indicate “B” in field 41, location l05 of Claim Detail l on an EMC bill).
- 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 *§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.*

140.4 - *Qualified Nonphysician Anesthetist* Special Billing and Payment Situations

(Rev.2634, Issued: 01-11-13, Effective: 01-01-13, Implementation: 02-12-13)

140.4.1 - An Anesthesiologist and *Qualified Nonphysician Anesthetist* Work Together

(Rev.2634, Issued: 01-11-13, Effective: 01-01-13, Implementation: 02-12-13)*Contractors* will distribute educational releases and use other established means to ensure that anesthesiologists understand the requirements for medical direction of *qualified nonphysician anesthetists. Contractors* will perform reviews of payments for anesthesiology services to identify situations in which an excessive number of concurrent anesthesiology services may have been performed. They will use peer practice and their experience in developing review criteria. They will also periodically review a sample of claims for medical direction of four

or fewer concurrent anesthesia procedures. During this process physicians may be requested to submit documentation of the names of procedures performed and the names of the anesthetists directed.

Physicians who cannot supply the necessary documentation for the sample claims must submit documentation with all subsequent claims before payment will be made.

140.4.2 - *Qualified Nonphysician Anesthetist* and an Anesthesiologist in a Single Anesthesia Procedure

(Rev.2634, Issued: 01-11-13, Effective: 01-01-13, Implementation: 02-12-13)

B3-4172.6

Where a single anesthesia procedure involves both a physician medical direction service and the service of the medically directed *qualified nonphysician anesthetist*, and the service is furnished on or after January 1, 1998, the payment amount for the service of each is 50 percent of the allowance otherwise recognized had the service been furnished by the anesthesiologist alone. The modifier to be used for current procedure identification is QX.

Beginning on or after January 1, 1998, where the *qualified nonphysician anesthetist* and the anesthesiologist are involved in a single anesthesia case, and the physician is performing medical direction, the service is billed in accordance with the following procedures:

- For the single medically directed service, the physician will use the modifier “QY” (MEDICAL DIRECTION *OF* ONE *QUALIFIED NONPHYSICIAN* ANESTHETIST BY AN ANESTHESIOLOGIST). This modifier is effective for claims for dates of service on or after January 1, 1998, and
- For the anesthesia service furnished by the medically directed *qualified nonphysician anesthetist, the qualified nonphysician anesthetist* will use the current modifier “QX.”

In unusual circumstances when it is medically necessary for both the *qualified nonphysician anesthetist* and the anesthesiologist to be completely and fully involved during a procedure, full payment for the services of each provider is allowed. The physician would report using the “AA” modifier and the *qualified nonphysician anesthetist* would use “QZ,” or the modifier for a nonmedically directed case. Documentation must be submitted by each provider to support payment of the full fee.

140.4.3 - Payment for Medical or Surgical Services Furnished by CRNAs

(Rev.2634, Issued: 01-11-13, Effective: 01-01-13, Implementation: 02-12-13)

B3-16003.H

Payment *shall* be made for *reasonable and necessary* medical or surgical services furnished by CRNAs if they are *legally authorized* to *perform* these services *in the state in which* services *are furnished*. Payment is determined under the physician fee schedule on the basis of the national physician fee schedule conversion factor, the geographic adjustment factor, and the resource-based relative value units for the medical or surgical service.

140.4.4 - Conversion Factors for Anesthesia Services of *Qualified Nonphysician Anesthetists* Furnished on or After January 1, 1992

(Rev.2634, Issued: 01-11-13, Effective: 01-01-13, Implementation: 02-12-13)

B3-16003.I, PM B-01-69

Conversion factors used to determine fee schedule payments for anesthesia services furnished *by qualified nonphysician anesthetists* on or after January 1, 1992, are determined based on a statutory methodology. For example, for anesthesia services furnished by a medically directed qualified *nonphysician* anesthetist in 1994, the medically directed allowance is 60 percent of the allowance that would be recognized for the anesthesia service if the physician personally performed the service without an assistant, i.e., alone. For

subsequent years, the medically directed allowance is the following percent of the personally performed allowance.

Services furnished in 1995	57.5 percent
Services furnished in 1996	55.0 percent
Services furnished in 1997	52.5 percent
Services furnished in 1998 and after	50.0 percent

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