Scope
This policy applies to all Commercial medical plans, Medicare Advantage plans, and Oregon Medicaid/OCCO plans.

Reimbursement Guidelines
The physician and the CRNA shall append the appropriate modifiers to indicate the medical direction of anesthesia or supervised anesthesia services provided.

Services submitted with modifiers QK, QX, and QY will be reimbursed at 50% of the applicable fee schedule rate, due to the supervision/services shared between two providers.

One anesthesia provider at a time shall be reimbursed per patient. The only exception is supervised anesthesia services by a CRNA under the medical direction of a physician.

If two anesthesia services claims are received for the same patient, same date of service, and no medical direction/supervision modifiers are appended, the first claim processed will be allowed. The second claim processed is subject to denial as services furnished by another provider. No adjustment for reimbursement to the second anesthesia provider can be made until a corrected claim is received from the first (allowed) anesthesia provider with the missing QK, QX, or QY modifier appended. The billing office for the denied claim is responsible to contact the billing office for the other anesthesia provider involved (supervised CRNA or physician providing medical direction) and arrange for the submission of the needed corrected claim.

Teaching Services
Claims for supervision of residents and student nurse anesthetist should be submitted with proper modifiers attached to the anesthesia codes.

• Services by the teaching physician must be submitted with modifier GC when supervising a single resident or student nurse.
No medical direction modifiers need to be appended if the teaching physician was personally present for the entire procedure.

If the teaching physician was personally present for only part of the procedure, modifier QY should also be appended.

- Services by the teaching physician must be submitted with modifier QK when supervising three or four residents or student nurse anesthetists concurrently.
- No reimbursement is made to residents or student nurse anesthetists.

**Background Information**

**Modifiers**

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

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

- To differentiate between the surgeon, assistant surgeon, and facility fee claims for the same surgery
- To indicate that a procedure was performed bilaterally
- To report multiple procedures performed at the same session by the same provider
- To report only the professional component or only the technical component of a procedure or service
- To designate the specific part of the body that the procedure is performed on (e.g. T3 = Left foot, fourth digit)
- To indicate special ambulance circumstances

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

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

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

**Anesthesia**

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

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

**Codes, Terms, and Definitions**

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Modifier QK</td>
<td>Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals</td>
</tr>
<tr>
<td>Modifier QX</td>
<td>CRNA service: with medical direction by a physician</td>
</tr>
<tr>
<td>Modifier QY</td>
<td>Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist</td>
</tr>
<tr>
<td>Modifier QZ</td>
<td>CRNA service: without medical direction by a physician</td>
</tr>
<tr>
<td>Modifier GC</td>
<td>This service has been performed in part by a resident under the direction of a teaching physician</td>
</tr>
</tbody>
</table>

**Coding Guidelines**

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

**Cross References**


References & Resources


IMPORTANT STATEMENT

The purpose of Moda Health Reimbursement Policy is to document payment policy for covered medical and surgical services and supplies. Health care providers (facilities, physicians and other professionals) are expected to exercise independent medical judgment in providing care to members. Reimbursement policy is not intended to impact care decisions or medical practice.

Providers are responsible for accurately, completely, and legibly documenting the services performed. The billing office is expected to submit claims for services rendered using valid codes from HIPAA-approved code sets. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS’ National Correct Coding Initiative (CCI/NCCI) Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the applicable member contract language. To the extent there are any conflicts between the Moda Health Reimbursement Policy and the member contract language, the member contract language will prevail, to the extent of any inconsistency. Fee determinations will be based on the applicable provider contract language and Moda Health reimbursement policy. To the extent there are any conflicts between Reimbursement Policy and the provider contract language, the provider contract language will prevail.