Anesthesia Billing Guide
August 2011

NHIC, Corp.
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INTRODUCTION

The Provider Outreach and Education Team at NHIC, Corp. developed this guide to provide you with Medicare Part B Anesthesia billing information. It is intended to serve as a useful supplement to other manuals published by NHIC, and not as a replacement. The information provided in no way represents a guarantee of payment. Benefits for all claims will be based on the patient’s eligibility, provisions of the Law, and regulations and instructions from the Centers for Medicare & Medicaid Services (CMS). It is the responsibility of each provider or practitioner submitting claims to become familiar with Medicare coverage and requirements. All information is subject to change as federal regulations and Medicare Part B policy guidelines, mandated by the CMS, are revised or implemented.

This information guide, in conjunction with the NHIC website (www.medicarenhic.com), J14 A/B MAC Resource (monthly provider newsletter), and special program mailings, provide qualified reference resources. We advise you to check our website for updates to this guide. To receive program updates, you may join our mailing list by clicking on “Join Our Mailing List” on our website. Most of the information in this guide is based on Publication 100-04, Chapter 12 of the CMS Internet Only Manual (IOM). The CMS IOM provides detailed regulations and coverage guidelines of the Medicare program. To access the manual, visit the CMS website at http://www.cms.gov/manuals/.

If you have questions or comments regarding this material, please call the Customer Service Center at 866-801-5304.

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GENERAL INFORMATION

A Physician, a Certified Registered Nurse Anesthetist (CRNA) or Anesthesiologist Assistant under the medical supervision of a physician, may provide anesthesia services. These services may include but are not limited to general, regional, supplementation of local anesthesia, or other supportive services in order to afford the patient the anesthesia care deemed optimal by the practitioner during any procedure. These services include the usual pre-operative or post-operative visits, the anesthesia care during the procedure, the administration of fluids and/or blood and the usual monitoring services (e.g., ECG, temperature, blood pressure, oximetry, capnography and mass spectrometry). Unusual forms of monitoring (e.g., intro-arterial, central venous and Swanz-Ganz catheters) are not included.

Provider Qualifications

Physician – Anesthesiologist
Physician is defined as a doctor of medicine who is legally authorized to practice in the State in which he/she performs services. The issuance of a license by a State to practice constitutes legal authorization. If the State licensing law limits the scope of practice of a particular type of medical practitioner, only the services within these limitations are covered.

Anesthesiologist Assistants and Certified Registered Nurse Anesthetists
For payment purposes, qualified anesthetists are Anesthesiologist Assistants and Certified Registered Nurse Anesthetists (CRNAs).

An Anesthesiologist Assistant is a person who:
• Is permitted by state law to administer anesthesia; and
• Has successfully completed a six (6) year program for Anesthesiologists Assistants of which two (2) 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 meeting the standards of the Council of Accreditation of Nurse Anesthesia Educational Programs and awaits initial certification.

Payment for the services of a CRNA may be made to the CRNA who furnished the anesthesia services or to a hospital, physician, group practice, or Ambulatory Surgical Center (ASC) with which the CRNA has an employment or contractual relationship.

NOTE: Locum Tenens Arrangements do not apply to CRNAs and Anesthesiologist Assistants.
GROUP PRACTICE

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

NOTE: However, only one member of the group would bill for the entire anesthesia service.

Medical Direction & Temporary Relief

CRNAs/AAs providing anesthesia services under the medical direction of an anesthesiologist must have uninterrupted immediate availability of an anesthesiologist at all times. When a medically directing anesthesiologist provides temporary relief to another anesthesia provider, the need for uninterrupted immediate availability may be met by any of the following strategies:

- A second anesthesiologist, not medically directing more than three concurrent procedures, may assume temporary medical direction responsibility for the relieving anesthesiologist. The transfer of responsibility from one physician to another should be documented in the medical record.
- Policy and procedure may require that the relieved provider remain in the immediate area and be available to immediately return to his/her case in the event the relieving anesthesiologist is required elsewhere. Adequate mechanisms for communication among staff must be in place.
- Policy and procedure requires that a specified anesthesiologist (e.g., O.R. Director) remain available at all times to provide substitute medical direction services for anesthesiologist(s) providing relief to anesthesia providers. This individual must not personally have ongoing medical direction responsibilities that would preclude temporarily assuming responsibility for additional case(s).

Personally Performed

The following criterion applies to anesthesia services personally performed:

- The physician personally performed the entire anesthesia service alone;
- The physician is involved with one anesthesia case with a resident and the physician is a teaching physician;
- 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 is continuously involved in a single case involving a student nurse anesthetist;
• If the physician is involved with a single case with a CRNA (or AA) contractors may pay the physician service and the CRNA (or AA) service in accordance with the medical direction payment policy; or
• The physician and the CRNA (or AA) are involved in one anesthesia case and the services of each are found to be medically necessary.

**Medical Direction**

Medical direction occurs if the physician medically directs qualified individuals in two, three, or four concurrent cases and the physician performs the following activities:

• Performs a pre-anesthesia examination and evaluation;
• Prescribes the anesthesia plan;
• Personally participates in the most demanding procedures of the anesthesia plan, including induction and emergence, if applicable;
• Ensures that any procedures in the anesthesia plan that he/she does not perform are performed by a qualified anesthetist;
• Monitors the course of anesthesia administration at frequent intervals;
• Remains physically present and available for immediate diagnosis and treatment of emergencies; and
• Provides indicated post-anesthesia care.

For medical direction services, the physician must document in the medical record that he or she performed the pre-anesthetic exam and evaluation. Physicians must also document that they provided indicated post-anesthesia care, were present during some portion of the anesthesia monitoring, and were present during the most demanding procedures, including induction and emergence, if applicable.

The physician can medically direct two, three, or four concurrent procedures involving qualified individuals, all of whom could be CRNAs, AAs, interns, residents or combinations of individuals. The medical direction rules apply to cases involving student nurse anesthetists if the physician directs two concurrent cases, each of which involves a student nurse anesthetist, or the physician directs one case involving a student nurse anesthetist and another involving a CRNA, AA, intern or resident.

For services furnished on or after January 1, 2010, the medical direction rules do not apply to a single resident case that is concurrent to another anesthesia case paid under the medical direction rules or to two concurrent anesthesia cases involving residents.
Concurrent Medically Directed Procedures

Concurrency is defined with regard to the maximum number of procedures that the physician is medically directing within the context of a single procedure and whether these other procedures overlap each other. Concurrency is not dependent on each of the cases involving a Medicare patient. For example, if an anesthesiologist directs three concurrent procedures, two of which involve non-Medicare patients and the remaining a Medicare patient, this represents three concurrent cases.

A physician who is concurrently directing the administration of anesthesia to not more than four (4) surgical patients cannot ordinarily be involved in rendering additional services to other patients. However, addressing an emergency of short duration in the immediate area, administering an epidural or caudal anesthetic to ease labor pain, or periodic, rather than continuous monitoring of an obstetrical patient, does not substantially diminish the scope of control exercised by the physician in directing the administration of anesthesia to the surgical patients. It does not constitute a separate service for the purpose of determining whether the medical direction criteria are met. Further, while directing concurrent anesthesia procedures, a physician may receive patients entering the operating suite for the next surgery, check or discharge patients in the recovery room, or handle scheduling matters without affecting fee schedule payment.

However, if the physician leaves the immediate area of the operating suite for other than short durations or devotes extensive time to an emergency case or is otherwise not available to respond to the immediate needs of the surgical patients, the physician’s services to the surgical patients are supervisory in nature. No fee schedule payment is made.

The examples listed above are not intended to be an exclusive list of allowed situations. It is expected that the medically-directing anesthesiologist is aware of the nature and type of services he or she is medically directing, and is personally responsible for determining whether his supervisory capacity would be diminished if he or she became involved in the performance of a procedure. It is the responsibility of this medically-directing anesthesiologist to provide services consistent with these regulations.

Medically Supervised

When an anesthesiologist is involved in rendering more than four procedures concurrently or is performing other services, while directing the concurrent procedures, the anesthesia services are considered medically supervised.
ANESTHESIA SERVICES

Medical and Surgical Services Rendered in Addition to Anesthesia Procedures

Payment may be made under the fee schedule for specific medical and surgical services by the anesthesiologist as long as these services are reasonable and medically necessary or provided other rebundling provisions do not preclude separate payment. These services may be rendered in conjunction with the anesthesia procedure to the patient or as single services (e.g., during the day of or the day before the anesthesia service). These services include the insertion of a Swan-Ganz catheter, the insertion of central venous pressure lines, emergency intubations, and critical care visits.

Payment can be made for medical or surgical services furnished by nonmedically directed CRNAs if they are allowed to furnish these services under State law. These services may include the insertion of Swan Ganz catheters, central venous pressure lines, pain management, emergency intubation, and the pre-anesthetic examination and evaluation of a patient who does not undergo surgery.

Medical and Surgical Services and Conscious Sedation

Anesthesia services range in complexity. The continuum of anesthesia services, from least intense to most intense in complexity is as follows: local or topical anesthesia, moderate (conscious) sedation, regional anesthesia and general anesthesia. Prior to 2006, Medicare did not recognize separate payment if the same physician provided the medical or surgical procedure and the anesthesia needed for the procedure.

Moderate sedation is a drug induced depression of consciousness during which the patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulation. Moderate sedation does not include minimal sedation, deep sedation or monitored anesthesia care. In 2006, the CPT added new codes 99143 to 99150 for moderate or conscious sedation. The moderate (conscious) sedation codes are contractor priced under the Medicare physician fee schedule.

The CPT codes 99143 to 99145 describe moderate sedation provided by the same physician performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status. The physician can bill the conscious sedation codes 99143 to 99145 as long as the procedure with it is billed is not listed in Appendix G of CPT. CPT codes 99148 to 99150 describe moderate sedation provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports.
The CPT includes Appendix G, Summary of CPT Codes That Include Moderate (Conscious) Sedation. This appendix lists those procedures for which moderate (conscious) sedation is an inherent part of the procedure itself. CPT coding guidelines instruct practices not to report CPT codes 99143 to 99145 in conjunction with codes listed in Appendix G. The National Correct Coding Initiative has established edits that bundle CPT codes 99143 and 99144 into the procedures listed in Appendix G.

In the unusual event when a second physician other than the health care professional performing the diagnostic or therapeutic services provides moderate sedation in the facility setting for the procedures listed in Appendix G, the second physician can bill 99148 to 99150. However, when these services are performed by the second physician in the nonfacility setting, CPT codes 99148 to 99150 are not to be reported.

If the anesthesiologist or CRNA provides anesthesia for diagnostic or therapeutic nerve blocks or injections and a different provider performs the block or injection, then the anesthesiologist or CRNA may report the anesthesia service using CPT code 01991. The service must meet the criteria for monitored anesthesia care. If the anesthesiologist or CRNA provides both the anesthesia service and the block or injection, then the anesthesiologist or CRNA may report the anesthesia service using the conscious sedation code and the injection or block. However, the anesthesia service must meet the requirements for conscious sedation and if a lower level complexity anesthesia service is provided, then the conscious sedation code should not be reported.

If the physician performing the medical or surgical procedure also provides a level of anesthesia lower in intensity than moderate or conscious sedation, such as a local or topical anesthesia, then the conscious sedation code should not be reported and no payment should be allowed by the contractor. There is no CPT code for the performance of local anesthesia and as payment for this service is considered in the payment for the underlying medical or surgical service.

**Monitored Anesthesia Care**

Monitored anesthesia care involves intraoperative monitoring by a physician or qualified individual under the medical direction of a physician or of the patient’s vital physiological signs in the anticipation of the need for administration of general anesthesia or of the development of adverse physiological patient reaction to the surgical procedure. It also includes the performance of a pre-anesthetic examination and evaluation, prescription of anesthesia care required, administration of any necessary oral or parenteral medications (e.g., atropine, demerol, valium) and provision of indicated post-operative anesthesia care.

Payment is made under the personally performed rate if the physician personally performs the monitored anesthesia care (see Payment at Personally Performed Rate). Payment is made under the medically directed payment rate if the physician medically directs four (4) or fewer concurrent cases and the monitored anesthesia care represents one (1) or more of these concurrent cases (see Payment at Medically Directed Rate).
Pain Management

Pain Management Consultation
Evaluation and management services for postoperative pain control on the day of surgery are considered part of the usual anesthetic services and are not separately reportable. When medically necessary and requested by the attending physician, hospital visits or consultative services are reportable by the anesthesiologist during the postoperative period. However, normal postoperative pain management, including management of intravenous patient controlled analgesia, is considered part of the surgical global package and should not be separately reported.

Postoperative Pain Control Procedures
When provided principally for postoperative pain control, peripheral nerve injections and neuraxial (spinal, epidural) injections can be separately reported on the day of surgery using the appropriate CPT procedure with modifier -59 (Distinct Procedural Service) and 1 unit of service. Examples of such procedures include:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>62310-62319</td>
<td>Epidural or subarachnoid injections</td>
</tr>
<tr>
<td>64415-64416</td>
<td>Brachial plexus injection, single or</td>
</tr>
<tr>
<td></td>
<td>continuous</td>
</tr>
<tr>
<td>64445-64448</td>
<td>Sciatic or femoral injections, single or</td>
</tr>
<tr>
<td></td>
<td>continuous</td>
</tr>
<tr>
<td>64449</td>
<td>Lumbar plexus injections, continuous</td>
</tr>
</tbody>
</table>

These services should not be reported on the day of surgery if they constitute the surgical anesthetic technique.

NOTE: Modifier 59 requires that the medical record substantiate that the procedure or service was a distinct or separate services performed on the same day.

Daily Management of Continuous Pain Control Techniques
Daily hospital management of continuous epidural or subarachnoid drug administration is reported using CPT code 01996 (1 unit of service daily). This code may be reported on the first and subsequent postoperative days as medically necessary.

When continuous infusion codes 64416, 64446, 64448, or 64449 are reported on the day of surgery, no additional reporting of daily management is permitted on the day of catheter placement. However, subsequent to the day of placement, catheter and infusion management should be reported using the appropriate visit code. CPT code 01996 should not be reported in conjunction with CPT codes 64416, 64446, 64448, or 64449.
Non-Covered Anesthesia Services
The following anesthesia services are non-covered:

- Stand By
- Anesthesia for dental services (if the dental service is non-covered, the anesthesia service is non-covered)
- Anesthesia for cosmetic surgery

TEACHING SERVICES

Anesthesia Services and Teaching Anesthesiologist
For anesthesia services furnished on or after January 1, 2010, 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 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 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 or electronic equivalent.

Use modifier GC (Teaching Physician Service) to indicate the service has been performed in part by a resident under the direction of a teaching physician. This modifier is added after the anesthesia modifier.

Anesthesia Services and Teaching CRNA
Payment can be made under Part B to a teaching CRNA who supervises a single case involving a student nurse anesthetist 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 student nurse anesthetist.
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 student nurse anesthetists. Payment is allowed if a teaching CRNA is involved with two student nurse anesthetists:

- Payment is allowed for the full base units (assigned to the anesthesia code) where the teaching CRNA is present with the student nurse anesthetist throughout pre and post anesthesia care; and

- Payment is allowed for the actual time the teaching CRNA is personally present with the student nurse anesthetist. Anesthesia time may be discontinuous. For example, a teaching CRNA is involved in two concurrent cases with student nurse anesthetists. 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 student nurse anesthetists. The documentation must be sufficient to support the payment of the fee and available for review upon request.

For services furnished on or after January 1, 2010, 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 student nurse anesthetists. Allow payment at the regular fee schedule rate if the teaching CRNA is involved with two concurrent student nurse anesthetist cases. The CRNA reports the anesthesia service using the “QZ” modifier.

To bill the anesthesia base units, the CRNA must be present with the student nurse anesthetist 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 student nurse anesthetist, the patient’s health status and other factors.

The teaching CRNA must document his/her involvement in the cases with the student nurse anesthetists. Use modifier GC (Teaching Physician Service) to indicate the service has been performed in part by a student nurse anesthetist under the direction of a teaching CRNA. This modifier is added after the anesthesia modifier.
PAYMENT AND REIMBURSEMENT

Payment at Personally Performed Rate
The fee schedule payment for a personally performed procedure is based on the full base unit and one time unit per 15 minutes of service if the physician personally performed the entire procedure. Modifier AA is appropriate when services are personally performed.

Payment at Medically Directed Rate
When the physician is medically directing a qualified anesthetist (CRNA, Anesthesiologist Assistant) in a single anesthesia case or a physician is medically directing 2, 3, or 4 concurrent procedures, the payment amount for each is 50% of the allowance otherwise recognized had the service been performed by the physician alone.

These services are to be billed as follows:
1. The physician should bill using modifier QY, medical direction of one CRNA by a physician or QK, medical direction of 2, 3, or 4 concurrent procedures.
2. The CRNA/Anesthesiologist Assistant should bill using modifier QX, CRNA service with medical direction by a physician.

Payment at Non-Medically Directed Rate
In unusual circumstances, when it is medically necessary for both the anesthesiologist and the CRNA/Anesthesiologist Assistant to be completely and fully involved during a procedure, full payment for the services of each provider are allowed. Documentation must be submitted by each provider to support payment of the full fee.

These services are to be billed as follows:
1. The physician should bill using modifier AA, anesthesia services personally performed by anesthesiologist, and modifier 22, with attached supporting documentation.
2. The CRNA/Anesthesiologist Assistant should bill using modifier QZ, CRNA/Anesthesiologist Assistant services; without medical direction by a physician, and modifier 22, with attached supporting documentation.

Payment at Medically Supervised Rate
Only three (3) base units per procedure are allowed when the anesthesiologist is involved in rendering more than four (4) procedures concurrently or is performing other services while directing the concurrent procedures. An additional time unit can be recognized if the physician can document he/she was present at induction. Modifier AD is appropriate when services are medically supervised.
Payment Rules
The fee schedule allowance for anesthesia services is based on a calculation that includes the anesthesia base units assigned to each anesthesia code, the anesthesia time involved, and appropriate area conversion factor. The following formulas are used to determine payment:

- **Participating Physician not Medically Directing (Modifier AA)**
  
  \[(\text{Base Units} + \text{Time Units}) \times \text{Participating Conversion Factor} = \text{Allowance}\]

- **Non-Participating Physician not Medically Directing (Modifier AA)**
  
  \[(\text{Base Units} + \text{Time Units}) \times \text{Non-Participating Conversion Factor} = \text{Allowance}\]

- **Participating Physician Medically Directing (Modifier QY, QK)**
  
  \[(\text{Base Units} + \text{Time Units}) \times \text{Participating Conversion Factor} = \text{Allowance} \times 0.5]\]

- **Non-Participating Physician Medically Directing (Modifier QY, QK)**
  
  \[(\text{Base Units} + \text{Time Units}) \times \text{Non-Participating Conversion Factor} = \text{Allowance} \times 0.5]\]

- **Non-Medically Directed CRNA (Modifier QZ)**
  
  \[(\text{Base Units} + \text{Time Units}) \times \text{Participating Conversion Factor} = \text{Allowance}\]

- **CRNA Medically Directed (Modifier QX)**
  
  \[(\text{Base Units} + \text{Time Units}) \times \text{Participating Conversion Factor} = \text{Allowance} \times 0.5]\]

Base Units
Each anesthesia code (procedure codes 00100-01999) is assigned a base unit value by the American Society of Anesthesiologists (ASA) and used for the purpose of establishing fee schedule allowances.

Anesthesia services are paid on the basis of a relative value system, which include both base and actual time units. Base units take into account the complexity, risk, and skill required to perform the service.

For the most current list of base unit values for each anesthesia procedure code can be found on the Anesthesiologist Center page on the CMS website at: [http://www.cms.gov/center/anesth.asp](http://www.cms.gov/center/anesth.asp)

Time Units
Anesthesia time is defined as the period during which an anesthesia practitioner is present with the patient. It starts when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ends when the anesthesia practitioner 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 practitioner can add blocks of time around an interruption in anesthesia time as long as the anesthesia practitioner is furnishing continuous anesthesia care within the time periods around the interruption.

For anesthesia claims, the elapsed time, in minutes, must be reported. Convert hours to minutes and enter the total minutes required for the procedure in Item 24G of the CMS-1500 claim form or electronic media claim equivalent.

Time units for physician and CRNA services - both personally performed and medically directed are determined by dividing the actual anesthesia time by 15 minutes or fraction thereof. Since only the actual time of a fractional unit is recognized, the time unit is rounded to one decimal place. The table below illustrates the conversion from minutes to units used by the contractor for processing:

<table>
<thead>
<tr>
<th>Minutes</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-2</td>
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</tr>
<tr>
<td>3</td>
<td>0.2</td>
</tr>
<tr>
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</tr>
<tr>
<td>6</td>
<td>0.4</td>
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<td>7-8</td>
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<td>9</td>
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<td>30</td>
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</tbody>
</table>

NOTE: Time Units are not recognized for CPT codes 01995 (Regional IV administration of local anesthetic agent or other medication (upper or lower extremity)) and 01996 (Daily hospital management of epidural or subarachnoid continuous drug administration).

Conversion Factors
Current anesthesia conversion factors can be found on the NHIC website at:

http://www.medicarenhic.com/ne_prov/fee_sched.shtml
Multiple Anesthesia Procedures
Payment may be made under the fee schedule for anesthesia services associated with multiple surgical procedures or multiple bilateral procedures. Payment is based on the base unit of the anesthesia procedure with the highest base unit value and the total time units based on the multiple procedures with the exception of the new add-on codes. On the CMS-1500 claim form, report the anesthesia procedure code with the highest base unit value in Item 24D. In Item 24G, indicate the total time for all the procedures performed.

Add-On Codes
Add-on codes exist for anesthesia involving burn excisions or debridement and obstetrical anesthesia. The add-on code is billed in conjunction to the primary anesthesia code. In the burn area, code 01953 is used in conjunction with code 01952. In the obstetrical area, code 01968 or 01969 is used in conjunction with code 01967. All anesthesia time should be reported only with the primary anesthesia code involving burn excisions or debridement. Anesthesia time for the obstetrical codes should be reported separately on the primary code and the add-on code.

BILLING AND CODING

Billing Instructions
Claims must be submitted on the claim Form CMS-1500 or electronic media claim equivalent. The following are specific to anesthesia claims submission:

• Item 24D – the appropriate anesthesia modifier must be reported
• Item 24G – the actual anesthesia time, in minutes, must be reported.

Modifiers
Anesthesia modifiers must be used with anesthesia procedure codes to indicate whether the procedure was personally performed, medically directed, or medically supervised.

AA Anesthesia services personally performed by the anesthesiologist
AD Medical supervision by a physician; more than four concurrent anesthesia services
G8 Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure (an informational modifier, does not affect reimbursement)
G9 MAC for a patient who has history of severe cardiopulmonary condition (an informational modifier, does not affect reimbursement)
Anesthesia Billing Guide

QK  Medical direction of two, three or four concurrent anesthesia procedures involving qualified individuals
QS  Monitored anesthesia care (an informational modifier, does not affect reimbursement)
QX  CRNA service with medical direction by a physician
QY  Medical direction of one CRNA by a physician
QZ  CRNA service without medical direction by a physician

NOTE: Medicare does not recognize Physical Status P modifiers.
NATIONAL CORRECT CODING INITIATIVE

The CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to eliminate improper coding. CCI edits are developed based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Manual, current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practice.

For the NCCI Policy Manual and the latest version of the NCCI Edits refer to the following website:  http://www.cms.gov/NationalCorrectCodInitEd/

If you have concerns regarding specific NCCI edits, please submit your comments in writing to:
National Correct Coding Initiative
Correct Coding Solutions LLC
P.O. Box 907
Carmel, IN 46082-0907

FAX: 317-571-1745

MEDICALLY UNLIKELY EDITS

The CMS developed Medically Unlikely Edits (MUEs) to reduce the paid claims error rate for Part B claims. An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service. All HCPCS/CPT codes do not have an MUE. The published MUE will consist of most of the codes with MUE values of 1-3. CMS will update the MUE values on its website on a quarterly basis. Although CMS publishes most MUE values on its website, other MUE values are confidential and are for CMS and CMS Contractors' use only. The latter group of MUE values should not be released since CMS does not publish them. For the latest version of the MUEs, refer to:

http://www.cms.gov/NationalCorrectCodInitEd/08_MUE.asp#TopOfPage

If you have concerns regarding specific MUEs, please submit your comments in writing to:

National Correct Coding Initiative
Correct Coding Solutions, LLC
P.O. Box 907
Carmel, IN 46082-0907

FAX: 317-571-1745
LIMITATION OF LIABILITY (ADVANCE BENEFICIARY NOTICE)

Services denied as not reasonable and medically necessary, under section 1862(a)(1) of the Social Security Act, are subject to the Limitation of Liability (Advance Beneficiary Notice (ABN)) provision. The ABN is a notice given to beneficiaries to convey that Medicare is not likely to provide coverage in a specific case. Providers must complete the ABN and deliver the notice to affected beneficiaries or their representative before providing the items or services that are the subject of the notice.

The ABN must be verbally reviewed with the beneficiary or his/her representative and any questions raised during that review must be answered before it is signed. The ABN must be delivered far enough in advance that the beneficiary or representative has time to consider the options and make an informed choice. ABNs are never required in emergency or urgent care situations. Once all blanks are completed and the form is signed, a copy is given to the beneficiary or representative. In all cases, the provider must retain the original notice on file.

Complete instructions and the ABN form (CMS-R-131) can be found on the CMS website at the following address:  http://www.cms.gov/BNI/

ABN Modifiers

GA  Waiver of liability statement issued, as required by payer policy, individual case
GX  Notice of liability issued, voluntary under payer policy
GY  Item or service statutorily excluded or does not meet the definition of any Medicare benefit
GZ  Item or service expected to be denied as not reasonable and necessary (forgot to issue ABN to patient)

Note: All claim line items submitted with a GZ modifier shall be denied automatically and will not be subject to complex medical review

LOCAL COVERAGE DETERMINATION (LCD)

Local Coverage Determinations are developed by the local Medicare contractor in the absence of a national Medicare payment policy. These policies describe specific criteria which determine whether an item or service is covered by Medicare and under what circumstances. LCDs are updated as new information and technology occurs in the field of medicine. NHIC has Local Coverage Determinations providing guidelines for various types of services. The LCDs can be found on the CMS website. The links for each state can be found on our website at:

http://www.medicarenhic.com/ne_prov/policies.shtml
NATIONAL COVERAGE DETERMINATION (NCD)

National Coverage Determinations are policies developed by CMS that indicates whether and under what circumstances certain services are covered under the Medicare program. NCDs are the same for all contractors across the country. More information about national coverage can be obtained through this website: http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx

MEDICARE FRAUD AND ABUSE

As the CMS J14 A/B MAC for Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont, NHIC fully supports the CMS initiative for program safeguards and shares the following information for your use:

Fraud is the intentional deception or misrepresentation that the individual knows to be false, or does not believe to be true and makes, knowing that the deception could result in some unauthorized benefit to himself/herself or some other person. The most frequent line of fraud arises from a false statement or misrepresentation made, or caused to be made, that is material to entitlement or payment under the Medicare program. Attempts to defraud the Medicare program may take a variety of forms. Some examples include:

- Billing for services or supplies that were not provided;
- Misrepresenting services rendered or the diagnosis for the patient to justify the services or equipment furnished;
- Altering a claim form to obtain a higher amount paid;
- Soliciting, offering, or receiving a kickback, bribe, or rebate;
- Completing Certificates of Medical Necessity (CMNs) for patients not personally and professionally known by the provider; and
- Use of another person’s Medicare card to obtain medical care.

Abuse describes incidents or practices of providers that are inconsistent with accepted sound medical practices, directly or indirectly resulting in unnecessary costs to the program, improper payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse takes such forms as, but is not limited to:

- Unbundled charges;
- Excessive charges;
- Medically unnecessary services; and
- Improper billing practices.

Although these practices may initially be considered as abuse, under certain circumstances they may be considered fraudulent. Any allegations of potential fraud or abuse should be referred to Safeguard Services (SGS).
If you wish to report fraud, or have any questions on Medicare Fraud and Abuse, please contact:

Maureen Akhouzine, Manager
Safeguard Services, LLC.
75 Sgt. William B. Terry Drive
Hingham, MA 02043
Phone 1-781-741-3282
Fax 1-781-741-3283
maureen.akhouzine@hp.com

A single number to report suspected fraud is the national OIG fraud hot line: **1-800-HHS-TIPS (1-800-447-8477)**. Information provided to hotline operators is sent out to state analysts and investigators.

**RECOVERY AUDIT CONTRACTOR**

The Centers for Medicare & Medicaid Services (CMS) has retained Diversied Collection Services (DCS) to carry out the Recovery Audit Contracting (RAC) program for Region A. The RAC program is mandated by Congress aimed at identifying Medicare improper payments. As a RAC, DCS will assist CMS by working with providers in reducing Medicare improper payments through the efficient detection and recovery of overpayments, the identification and reimbursement of underpayments and the implementation of actions that will prevent future improper payments. For more information please click on [http://www.dcsrac.com/](http://www.dcsrac.com/)

**COMPREHENSIVE ERROR RATE TESTING**

In an effort to determine the rate of Medicare claims that are paid in error, CMS developed the Comprehensive Error Rate Testing (CERT) program. This program will determine the paid claim error rates for individual Medicare contractors, specific benefit categories, and the overall national error rate. This is accomplished by sampling random claims on a nationwide basis, while insuring that enough claims are sampled to evaluate the performance of each Medicare contractor. The CERT program is administered by two contractors:

**CERT DOCUMENTATION CONTRACTOR (CDC)** - The CDC requests and receives medical records from providers.

**CERT REVIEW CONTRACTOR (CRC)** - The CRC’s medical review staff reviews claims that are paid and validate the original payment decision to ensure that the decision was appropriate. The sampled claim data and decisions of the independent medical reviewers will be entered into a tracking and reporting database.

The outcomes from this project are a national paid claims error rate, a claim processing error rate, and a provider compliance rate. The tracking database allows us to quickly identify emerging trends.

For more information please click on [http://www.cms.gov/CERT/](http://www.cms.gov/CERT/)
Provider Interactive Voice Response (IVR) Directory

All actively enrolled providers must utilize the IVR for: Beneficiary Eligibility, Deductible, Claim Status, Check Status and Earnings to Date. The IVR can also assist you with the following information: Seminars, Telephone Numbers, Addresses, Medicare News and Appeal Rights.

CMS requires the National Provider Identifier (NPI), Provider Transaction Access Number (PTAN), and the last 5-digits of the tax identification number (TIN) or social security number (SSN) of the provider to utilize the IVR system.

Available 24 hours/day, 7 days/week (including holidays)

888-248-6950

Provider Customer Service Directory

Our Customer Service representatives will assist you with questions that cannot be answered by the IVR, such as policy questions, specific claim denial questions, 855 application status, and redetermination status. Per CMS requirements, the Customer Service representatives may not assist providers with Beneficiary Eligibility, Deductible, Claim Status, Check Status and Earnings to Date unless we are experiencing IVR system problems.

Hours of Operation:
8:00 a.m. to 4:00 p.m. Monday – Thursday
10:00 a.m. to 4:00 p.m. - Friday
866-801-5304

Dedicated Reopening Requests Only
Hours of Operation:
8:00 a.m. to 12:00 p.m. and 12:30 p.m. to 4:00 p.m. Monday – Thursday
10:00 a.m. to 12:00 p.m. and 12:30 p.m. to 4:00 p.m. - Friday
877-757-7781
PROVIDER ENROLLMENT HELP LINE

A Customer Service Enrollment Specialist will be able to assist with your CMS-855 application inquiries. To help expedite your call, please have your CCN, PTAN and/or NPI number available.

Through the Provider Enrollment Help Line you can:
- Resolve your complex enrollment inquiries
- Schedule an appointment with a Provider Enrollment Specialist
- Receive individual assistance as you complete your PECOS Web Application

Toll Free Number (888) 300-9612
Phone Options:
- Press 1 for Part B Application Inquiries
- Press 2 for Part A and RHHI Application Inquiries
- Press 3 if you are returning an application verification call
- Press 4 if you need assistance completing your PECOS Web Application
- Or stay on the line for the next available representative.

Please note: The Provider Enrollment Help Line should not be used for checking status of your application. For application status inquiries, please visit our website at www.medicarenhic.com and go to "check enrollment status".

PROVIDER ENROLLMENT STATUS INQUIRY TOOL

This inquiry tool can be used to check on the status of your CMS-855 application. http://www.medicarenhic.com/ne_prov/PartB_enrollment_search_form.shtml

The three possible statuses would be:
Screening: The application is being reviewed for signatures, missing sections/documents
Processing: Information on the application is being verified or request for additional information is in process
Finalized: The application has been approved, returned, rejected or denied

How to Search:
Individual Application: Type in your last name and first name
Group Application: Type in your Group Name

Note: The search results will be limited to the last six months of application activity. For any information beyond this timeframe, please contact Customer Service.
# MAILING ADDRESS DIRECTORY

<table>
<thead>
<tr>
<th>Category</th>
<th>Address 1</th>
<th>Address 2</th>
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<tr>
<td>Initial Claim Submission</td>
<td>P.O. Box 2323</td>
<td>Hingham, MA 02044</td>
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<td>Maine</td>
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<td>Massachusetts</td>
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<td>New Hampshire</td>
<td>P.O. Box 1717</td>
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<td>Rhode Island</td>
<td>P.O. Box 9203</td>
<td>Hingham, MA 02044</td>
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<tr>
<td>Vermont</td>
<td>P.O. Box 7777</td>
<td>Hingham, MA 02044</td>
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<td>EDI (Electronic Data Interchange)</td>
<td>P.O. Box 9104</td>
<td>Hingham, MA 02044</td>
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<td>Written Correspondence</td>
<td>P.O. Box 1000</td>
<td>Hingham, MA 02044</td>
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<td>Medicare Reopenings and Redeterminations</td>
<td>P.O. Box 3535</td>
<td>Hingham, MA 02044</td>
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<td>Medicare B Refunds</td>
<td>P.O. Box 809150</td>
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<td>Medicare Secondary Payer (Correspondence Only)</td>
<td>P.O. Box 9100</td>
<td>Hingham, MA 02044</td>
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<td>Provider Enrollment</td>
<td>P.O. Box 3434</td>
<td>Hingham, MA 02044</td>
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<tr>
<td>Medicare Safeguard Services</td>
<td>P.O. Box 4444</td>
<td>Hingham, MA 02044</td>
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**Note:** Reopening requests may be faxed to NHIC at **1-781-741-3534** using the NHIC Corp. Clerical Error Reopening Request Form that can be downloaded from our Web site: [http://www.medicarenhic.com/ne_prov/forms.shtml](http://www.medicarenhic.com/ne_prov/forms.shtml)
PROVIDER SERVICES PORTAL (PSP)

The Provider Services Portal (PSP) is a website tool that offers the provider community an alternative to the IVR or Customer Service Toll Free line.

This tool offers the following information through lookup transactions and there is no charge to access the PSP:

- Beneficiary Eligibility
- Claim Status
- Standard Paper Remittances with the ability to select and print SPR’s locally
- Provider Summary
- Provider Enrollment Status

The PSP has superior search capability and will allow you to research your claims quickly and efficiently! The PSP is available 24 hours a day, 7 days a week, except during scheduled maintenance windows.

How To Get Started: [http://www.medicarenhic.com/ne_prov/psphome_index.shtml](http://www.medicarenhic.com/ne_prov/psphome_index.shtml)

DURABLE MEDICAL EQUIPMENT (DME)

Durable Medical Equipment (DME) Medicare Administrative Contractor:

NHIC, Corp.   Provider Service Line:  1-866-419-9458

Please view the website to find the appropriate address: [http://www.medicarenhic.com/dme/contacts.shtml](http://www.medicarenhic.com/dme/contacts.shtml)

RECONSIDERATION (SECOND LEVEL OF APPEAL)

C2C Solutions, Inc.
QIC Part B North Reconsiderations
P.O. Box 45208
Jacksonville, FL  32232-5208
INTERNET RESOURCES

The Internet is a very valuable tool in researching certain questions or issues. NHIC has a comprehensive website that serves as a direct source to Medicare as well as a referral tool to other related websites that may prove to be beneficial to you.

NHIC, Corp.

http://www.medicarenhic.com

Upon entering NHIC’s web address you will be first taken straight to the “home page” where there is a menu of information. NHIC’s web page is designed to be user-friendly.

We encourage all providers to join our website mailing list. Just click the link on the home page entitled “Join Our Mailing List”. You may also access the link directly at:
http://visitor.constantcontact.com/email.jsp?m=1101180493704

When you select the “General Website Updates”, you will receive a news report every week, via e-mail, letting you know what the latest updates are for the Medicare program. Other Web News selections (Updates, EDI, etc.) will be sent out on an as-needed basis.

Provider Page Menus/Links
From the home page, you will be taken to the License for use of “Physicians’ Current Procedural Terminology”, (CPT) and “Current Dental Terminology”, (CDT). Near the top of the page are two buttons, “Accept” and “Do Not Accept”. Once you click “Accept”, you will be taken to the provider pages.

On the left side of the web page you will see a menu of topics that are available. Explore each one and bookmark those that you use most often.

Medicare Coverage Database

http://www.cms.gov/center/coverage.asp

The Medicare Coverage Database is an administrative and educational tool to assist providers, physicians and suppliers in submitting correct claims for payment. It features Local Coverage Determinations (LCDs) developed by Medicare Contractors and National Coverage Determinations (NCDs) developed by CMS. CMS requires that local policies be consistent with national guidance (although they can be more detailed or specific), developed with scientific evidence and clinical practice.
Medicare Learning Network

http://www.cms.gov/MLNGenInfo/

The Medicare Learning Network (MLN) website was established by CMS in response to the increased usage of the Internet as a learning resource by Medicare health care professionals. This website is designed to provide you with the appropriate information and tools to aid health care professionals about Medicare. For courses and information, visit the web site. For a list of the Training Programs, Medicare Learning Network Matters articles and other education tools available, visit the website.

Open Door Forums

http://www.cms.gov/OpenDoorForums/

CMS conducts Open Door Forums. The Open Door Forum addresses the concerns and issues of providers. Providers may participate by conference call and have the opportunity to express concerns and ask questions. For more information, including signing up for the Open Door Forum mailing list, visit the website.

Publications and Forms

http://www.cms.gov/CMSForms/

For your convenience CMS has published optional forms, standard forms, and SSA forms. By linking onto this website, you can access numerous CMS forms such as:

- Provider Enrollment CMS 855 forms (CMS 855B, 855I, & 855R)
- Medicare Participating Physician or Supplier Agreement (CMS 460)
- Advanced Beneficiary Notices (ABN) (CMS R-131)
- Medicare Redetermination Request Form (CMS 20027)
- Request for Reconsideration (CMS 20033)
- Medicare Managed Care Disenrollment form (CMS 566)

Advance Beneficiary Notice (ABN) http://www.cms.gov/BNJ/

American Medical Association http://www.ama-assn.org/

CMS http://www.cms.gov

http://www.medicare.gov

CMS Correct Coding Initiative http://www.cms.gov/NationalCorrectCodInitEd/


Clinical Lab Improvement Amendment http://www.cms.gov/CLIA/01_Overview.asp#TopOfPage

NHIC, Corp.

REF-EDO-0005 Version 5.0

The controlled version of this document resides on the NHIC Quality Portal (SharePoint). Any other version or copy, either electronic or paper, is uncontrolled and must be destroyed when it has served its purpose.
Electronic Prescribing  http://www.cms.gov/erxincentive/

Electronic Health Records http://www.cms.gov/ehrincentiveprograms/

Evaluation and Management Documentation Guidelines  

Federal Register  
http://www.archives.gov/federal-register 
http://www.gpoaccess.gov/index.html

HIPAA  
http://www.cms.gov/HIPAAGenInfo/

ICD-10  
http://www.cms.gov/icd10/

National Provider Identifier (NPI)  
http://www.cms.gov/NationalProvIdentStand/

NPI Registry  
https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do

Physicians Quality Reporting System  http://www.cms.gov/POQS//

Provider Enrollment, Chain, and Ownership System (PECOS)  
http://www.cms.gov/MedicareProviderSupEnroll/04_InternetbasedPECOS.asp#TopOfPag

Provider Enrollment  
http://www.cms.gov/MedicareProviderSupEnroll/

Skilled Nursing Facility Consolidated Billing  
http://www.cms.gov/snfconsolidatedbilling/01_overview.asp?

U.S. Government Printing Office  
http://www.gpoaccess.gov/index.html


5010  
http://www.cms.gov/Versions5010andD0/40_Educational_Resources.asp#TopOfPage
## Anesthesia Billing Guide

### Revision History:

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<td>1.0</td>
<td>07/06/2010</td>
<td>Susan Kimball</td>
<td>Ayanna Yancey-Cato</td>
<td>Release of document in the new NHIC Quality Portal</td>
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<td>2.0</td>
<td>08/30/2010</td>
<td>M. Franco</td>
<td>Ayanna Yancey-Cato</td>
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<td>Susan Kimball</td>
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<td>4.0</td>
<td>05/25/11</td>
<td>Susan Kimball</td>
<td>Ayanna Yancey-Cato</td>
<td>Annual Review, added descriptor of anesthesia, updated personally performed, medically directed, added CRNA medical services, updated conscious sedation, added CRNA teaching, updated non-covered</td>
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