

Payment Policies for Anesthesia Services

There are differences in Medicare payment policies between a teaching anesthesiologist involved with two concurrent cases with residents and a teaching CRNA involved with two concurrent cases with student nurse anesthetists.

Currently, if a teaching anesthesiologist is involved with two concurrent cases with anesthesia residents, the medical direction rules apply. Payment for the physician's medical direction is based on 50 percent of the allowance otherwise allowed if the anesthesiologist performed the anesthesia case alone.

For anesthesia services furnished prior to July 1, 2002, we allowed full payment if a non-medically directed certified registered nurse anesthetist (CRNA) supervised a single case involving a student nurse anesthetist. No payment was made if the teaching CRNA supervised two cases involving student nurse anesthetists. In August 2002, we released the Medicare Carriers Manual Transmittal 1766 relating to the involvement of a non-medically directed teaching CRNA with two student nurse anesthetists. The American Association of Nurse Anesthetists (AANA) noted that their standards for approved nurse anesthesia training programs allow the teaching CRNA to supervise two concurrent cases involving student nurse anesthetists. The new policy allows the teaching CRNA to be paid, for his/her involvement with two concurrent cases with student nurse anesthetists, but not at the full fee level. If a teaching CRNA is involved with two concurrent cases with student nurse anesthetists, payment may be based on the base unit plus the time that the teaching CRNA is present with the student nurse anesthetist. To bill the base unit, the teaching CRNA must be present with the student nurse anesthetist throughout the pre- and post-anesthesia care. This payment per case is usually higher than the 50 percent paid to the teaching anesthesiologist for medically directing resident cases.

In the proposed rule, we asked for comments on the appropriateness of applying the CRNA teaching/resident policy to teaching anesthesiologists.

Comment: The American Association of Nurse Anesthetists commented that it was unclear how the new rule for teaching anesthesiologists would operate with the medical direction rules, particularly if there were more than two concurrent anesthesia cases.

Response: The new policy for teaching anesthesiologists would apply only when there are two concurrent cases, and the cases involve residents. The medical direction payment policy would continue to apply, as it has previously, for three or four concurrent anesthesia cases regardless of the qualified individual (for example, CRNA, resident, or anesthesiologist assistant) who is administering and monitoring anesthesia under the physician's medical direction.

Comment: The ASA requested that the teaching anesthesiology payment regulations be revised so that the teaching anesthesiologists be paid in a similar manner to teaching surgeons. Under the teaching physician rules, the teaching surgeon can be paid the full fee for each of two overlapping surgeries involving residents. The ASA understands that such a proposal would require a revision to Medicare regulations and would require rulemaking.

The ASA requested that, at least, in the interim, we allow teaching anesthesiologists to be paid similarly to teaching CRNAs for two concurrent cases. However, ASA specifically requested that this policy be used in addition to the current medical direction payment policy. In other words, the ASA wants the teaching anesthesiologist to be able to choose case-by-case, whether to seek payment similar to the teaching CRNA (that is, full base units and time units based only on actual presence with the resident) or based on the medical direction rules (that is, 50 percent of the full base and time units).

According to the ASA, a number of anesthesiology department heads believe the nurse anesthesia payment rule is not appropriate to the teaching of already-licensed physicians. They question the need for the teaching physician to participate in the pre- and post-op anesthesia care (to obtain full base units), they think that participation of the teaching anesthesiologist in the key portions of the procedure is far more important than the number of minutes present with the resident (which is the relevant consideration under the teaching physician policy for a single case with a resident).

Response and Final Decision

We have decided to allow teaching anesthesiologists to bill, similarly to teaching CRNAs, for their involvement in two concurrent cases involving residents. This will apply to anesthesia services furnished on or after January 1, 2004.

The anesthesiologist can bill base units and actual time, based on the amount of time the physician is present with the resident during each of two concurrent cases. To bill base units, the physician must be present with the resident during the pre- and post-anesthesia care included in the base units. If the physician is not present with the resident during the pre- and post-anesthesia care, the physician may bill the case as a medically directed case.

The anesthesiologist must document his/her involvement in cases with anesthesia residents. The documentation must be sufficient to support the payment of the fee and available for review upon request. We have revised § 414.46 to incorporate this change.

F. Technical Correction

CPT Code 96155 (*Health and behavior intervention, each 15 minutes, face-to-face; family (without the patient present)*)

This code describes a visit with a patient's family without the patient being present and was first included in the November 1, 2001 final rule. It was incorrectly listed as an active code for which payment could be made under the physician fee schedule. Our longstanding payment policy is that we do not pay for visits with family where the patient is not present. Payment for such visits is included in the pre- and post-service work of a visit where the patient is present. Consistent with this policy, this code is not payable under the physician fee schedule.

Comment: A few commenters urged us to continue to list this code as an active code under the fee schedule as they do not agree with our policy. The commenters do not agree with our assertion that payment for such visits is included in the pre- and post-service work of a visit when the patient is present and believe that not covering the service could result in diminished quality of care. One commenter disagreed that this was a technical correction since this code is currently being paid for under the fee schedule.

Response: As we indicated in the proposed rule, this was erroneously listed as an active code, contrary to longstanding Medicare policy. To be consistent with our policy, no payment may be made for this service under Medicare, and the code will be assigned a status indicator of "N".

G. Incomplete Screening Colonoscopy

Section 1834(d)(3) of the Act requires that the payment amount for a screening colonoscopy be set at the level for a