RELI Group
5520 Research Park Dr. #105
Catonsville, MD 21228

March 9, 2020

CBR #: CBR202002
Anesthesia Modifiers

NPI #:
Fax #:
Email address:

Organization Name 1
Address 1
Address 2
City, State, ZIP

Dear Medicare Provider:

The Centers for Medicare & Medicaid Services (CMS) strives to protect the Medicare Trust Fund and effectively manage Medicare resources. To support these goals, CMS has contracted with the RELI Group to develop this Comparative Billing Report (CBR) and to support providers with its use.

What is a CBR? A CBR is an educational tool that reflects your billing and/or prescribing patterns as compared to your peers' patterns for the same services in your state or specialty, and nationwide. The CBR is intended to enhance accurate billing and/or prescribing practices and support providers' internal compliance activities.

Why did I get a CBR? We are providing this report because your Medicare billing and/or prescribing patterns differ from your peers' patterns within your state/specialty and/or across the nation. Receiving this CBR is not an indication or precursor to an audit, and it requires no response on your part. Selected providers, however, may be referred for additional review and education.

Please carefully review this report. You may wish to check your records against data in CMS' files and review Medicare guidelines to ensure compliance. Contact your Medicare Administrative Contractor (MAC) with specific billing or coding questions. **As appropriate, please share this CBR with others who may benefit from and/or assist with interpreting the data provided in the report.**

To access an electronic copy of your CBR: Visit the secure CBR portal at https://cbrfile.cbrpepper.org/. Populate the fields, and in the "validation code" field, enter your unique validation code: **(code here)**

For more information: Register for our free webinar, scheduled for Mar. 19, 2020 at 3 p.m. ET, at CBR.CBRPEPPER.org. If you are unable to attend the live event, you may access the recording and additional resources at CBR.CBRPEPPER.org.

To request assistance or submit questions: Contact the CBR Help Desk at https://CBR.CBRPEPPER.org/Help-Contact-Us or call 1-800-771-4430 (M–F, 9 a.m.–5 p.m. ET).

Sincerely,
The CBR Team

REMINDER: Please ensure your email address and fax number are updated in the following systems:

- National Plan and Provider Enumeration System (NPPES): https://nppes.cms.hhs.gov/#/
- Provider Enrollment, Chain, and Ownership System (PECOS): https://pecos.cms.hhs.gov/pecos/login.do#headingLv1

THIS PAGE LEFT INTENTIONALLY BLANK

Comparative Billing Report (CBR) 202002
March 9, 2020
Anesthesia Modifiers

Introduction

CBR202002 focuses on rendering providers who perform anesthesia services, with a focus on providers who submit anesthesia services with modifiers AA and AD. The analysis in this CBR reflects the submission of claims for Current Procedural Terminology® (CPT®) codes for anesthesia services (00100 – 01999) in conjunction with modifiers AA, AD, G8, G9, QK, QS, QX, QY, and QZ, all of which are defined in Table 1. The data analysis comprises all submissions of anesthesia claims that used the modifiers listed in Table 1. For the purposes of this document, the term "anesthesia services" refers to CPT® codes 00100 – 01999, and the term "modifiers" refers only to the modifiers AA, AD, G8, G9, QK, QS, QX, QY, and QZ.

According to the *2019 Medicare Fee-for-Service Supplemental Improper Payment Data* report, the projected improper payment rate for anesthesia, as a service type, was 7.3%, representing $156,137,236 in projected improper Medicare payments. The same report identifies anesthesiology, as a provider type, as having a projected improper payment rate of 7.1%, representing $123,590,626 in projected improper Medicare payments. Of those projected improper payments, 79.6% were due to insufficient documentation. This represents a considerable increase from the rate reported in the *2018 Medicare Fee-for-Service Supplemental Improper Payment Data* report, which reflected a 2.0% projected improper payment rate for anesthesia, representing $36,427,656 in projected improper Medicare payments.

In "Chapter II: Anesthesia Services" of the *National Correct Coding Initiative (NCCI) Policy Manual for Medicare Services*, CMS describes anesthesia coding characteristics as follows: "A unique characteristic of anesthesia coding is the reporting of time units. Payment for anesthesia services increases with time. In addition to reporting a base unit value for an anesthesia service, the anesthesia practitioner reports anesthesia time…Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service."

The criteria for receiving a CBR are that a provider:

1. Is significantly higher compared to either state or national averages or percentages in any of the three metrics (i.e., greater than or equal to the 90th percentile), and
2. Has at least 50 beneficiaries with claims for CPT® codes 00100 – 01999, and
3. Has at least $20,000 or more in total allowed charges.

Coverage and Documentation Overview

This portion of the CBR offers a broad look at the coverage and documentation requirements to ensure compliance with Medicare guidelines. The information provided does not supersede or alter any coverage and documentation policies outlined by the MACs' Local Coverage Determinations.

In "Chapter 12, Section 50," of the *Medicare Claims Processing Manual*, CMS provides the following guidance for the documentation of anesthesiology services: "The physician must document in the medical record that he or she performed the pre-anesthetic examination 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 in the anesthesia plan, including induction and emergence, where indicated."

Table 1 identifies the modifiers used in the CBR analysis for anesthesia services, as defined in "Chapter 12, Section 50," of the *Medicare Claims Processing Manual* and the *CMS Manual System, Pub. 100-04 Medicare Claims Processing, Transmittal 2716, Change Request 8180*.

Table 1: Modifier Descriptions

Modifier	Description
AA	Anesthesia services performed personally by an anesthesiologist
AD	Medical supervision by a physician; more than four concurrent anesthesia procedures
G8	Monitored anesthesia care for deep complex, complicated, or markedly invasive surgical procedures
G9	Monitored anesthesia care for a patient who has a history of severe cardio-pulmonary condition
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals
QS	Monitored anesthesia care service
QX	Qualified non-physician anesthetist with medical direction by a physician
QY	Medical direction of one qualified non-physician anesthetist by an anesthesiologist
QZ	Certified registered nurse anesthetists (CRNA) without medical direction by a physician

Table 2 identifies a summary of your utilization of CPT® codes for anesthesia services (CPT® codes 00100 – 01999) between Oct. 1, 2018, and Sept. 30, 2019.

Table 2. Summary of Your Utilization of CPT® Codes for Anesthesia Services Between Oct. 1, 2018, and Sept. 30, 2019

Anesthesia Services CPT® Codes	Allowed Charges	Allowed Units	Beneficiary Count
Total	$52,922.57	867	157

Metrics

This report is an analysis of the following metrics:

1. Percent of anesthesia services allowed with AA or AD modifiers
2. Average allowed amount per claim for anesthesia services
3. Average number of anesthesia units of service allowed per claim with an AA or AD modifier

The CBR team analyzed the claims submitted by rendering providers for anesthesia services, with a focus on providers who submitted anesthesia services with modifiers AA and AD. Claims for beneficiaries who received anesthesia services were analyzed. Statistics were calculated for each provider, all providers in the state, and all providers in the nation. The state and national peer groups are defined as follows:

- The state peer group is defined as all rendering Medicare providers practicing in the individual provider's state or territory with allowed charges for the procedure codes included in this study.
- The national peer group is defined as all rendering Medicare providers in the nation with allowed charges for the procedure codes included in this study.

Each provider's values are compared to his/her state peer group values and to the national values. Your metrics were compared to your state [state code] and the nation. There are four possible outcomes for the comparisons between the provider and his/her peer groups:

1. Significantly Higher — Provider's value is greater than or equal to the 90th percentile from the state or national mean.
2. Higher — Provider's value is greater than the state or national mean.
3. Does Not Exceed — Provider's value is less than or equal to the state or national mean.
4. Not Applicable (N/A) — Provider does not have sufficient data for comparison.

Methods and Results

This report is an analysis of rendering providers who submitted claims for anesthesia services. The analyzed claims were extracted from the Integrated Data Repository, based on the latest version of claims available on Jan. 30, 2020. The analysis includes claims with dates of service from Oct. 1, 2018, through Sept. 30, 2019. For the trend analysis presented in Figure 1, claims represent dates of service between Oct. 1, 2016, and Sept. 30, 2019.

There are 92,583 rendering providers nationwide who submitted claims for anesthesia services. The total allowed charges for these claims were $2.7 billion dollars during that timeframe.

Metric 1: Percent of Anesthesia Services Allowed with AA or AD Modifiers

Table 3 shows the percent of anesthesia services allowed with AA or AD modifiers. This is calculated as follows:

- The total number of allowed claims for anesthesia services with an AA or AD modifier (numerator) is divided by the total number of allowed claims for anesthesia services (denominator). The result is multiplied by 100.

$$\left(\frac{\text{Allowed claims for anesthesia services with an AA or AD modifier}}{\text{Allowed claims for anesthesia services}}\right) \text{x100}$$

Your comparison in your state and in the nation is presented in Table 3.

Table 3: Your Percent of Anesthesia Services Allowed with AA or AD Modifiers

Anesthesia Claims with AA or AD Modifiers	Anesthesia Claims	Your Percent	Your State Percent	Comparison with Your State	National Percent	Comparison with National Percent
164	164	100%	37.27%	Significantly Higher	25.53%	Significantly Higher

Metric 2: Average Allowed Amount per Claim for Anesthesia Services

Table 4 shows the average allowed amount per claim for anesthesia services. This is calculated as follows:

- The total allowed amount for claims for anesthesia services (numerator) is divided by the total number of claims for anesthesia services (denominator).

$$\frac{\text{Total allowed amount for claims for anesthesia services}}{\text{Total number of claims for anesthesia services}}$$

Your comparison in your state and in the nation is presented in Table 4.

Table 4: Your Average Allowed Amount per Claim for Anesthesia Services

Allowed Amount for Anesthesia Services	Number of Anesthesia Claims	Your Average	Your State Average	Comparison with Your State	National Average	Comparison with National Average
$52,922.57	164	$322.70	$321.58	Higher	$186.22	Significantly Higher

Metric 3: Average Number of Anesthesia Units of Service Allowed per Claim with an AA or AD Modifier

Table 5 shows the average number of anesthesia units of service allowed per claim with an AA or AD modifier. This is calculated as follows:

- The total number of allowed units for claims for anesthesia services with an AA or AD modifier (numerator) is divided by the total number of claims for anesthesia services with an AA or AD modifier (denominator).

$$\frac{\text{Total number of allowed units for claims for anesthesia services with an AA or AD modifier}}{\text{Total number of claims for anesthesia services with an AA or AD modifier}}$$

Your comparison in your state and in the nation is presented in Table 5.

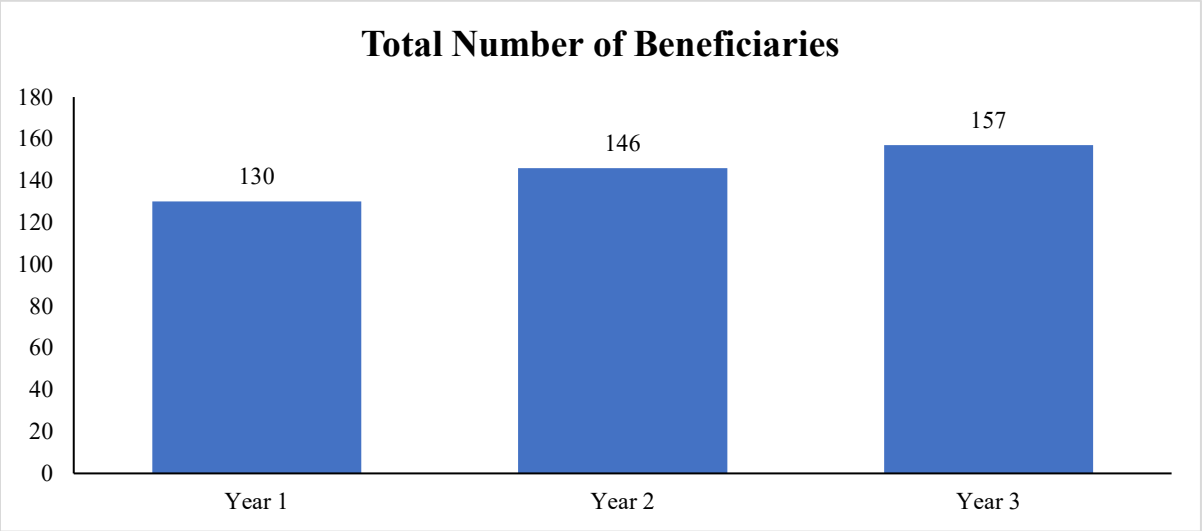
Table 5: Your Average Anesthesia Units of Service Allowed per Claim with an AA or AD Modifier

Allowed Units for Anesthesia with AA or AD Modifier	Claims for Anesthesia with AA or AD Modifier	Your Average	Your State Average	Comparison with Your State	National Average	Comparison with National Average
867	164	5.28	6.59	Does Not Exceed	6.40	Does Not Exceed

Figure 1 illustrates the trend over time of the total number of beneficiaries who received anesthesia services with claims submitted for CPT® codes 00100 – 01999. Year 1, Year 2, and Year 3 are defined as follows:

- Year 1: Oct. 1, 2016 – Sept. 30, 2017
- Year 2: Oct. 1, 2017 – Sept. 30, 2018
- Year 3: Oct. 1, 2018 – Sept. 30, 2019

Figure 1: Analysis of Trends Over Time for Total Number of Beneficiaries with Submitted Claims for Anesthesia Services



References and Resources

2018 Medicare Fee-for-Service Supplemental Improper Payment Data, CMS

2019 Medicare Fee-for-Service Supplemental Improper Payment Data, CMS

CMS Manual System, Pub. 100-04 Medicare Claims Processing, Transmittal 2716, Change Request 8180, CMS

CPT® Professional Edition, American Medical Association

Medicare Claims Processing Manual, "Chapter 12, Section 50," CMS

NCCI Policy Manual for Medicare Services, "Chapter II: Anesthesia Services," CMS