Medicare
Carriers Manual
Part 3 - Claims Process

Department of Health & Human Services (DHHS)
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HEADER SECTION NUMBERS	PAGES TO INSERT	PAGES TO DELETE
16004 - 16007	16-11 - 16-14 (4 pp.)	16-11 - 16-13 (3 pp.)

NEW/REVISED MATERIAL--*EFFECTIVE DATE: July 1, 2002*
IMPLEMENTATION DATE: August 29, 2002

Section 16003 J., Anesthesia Services and Teaching CRNA, is a new section. It allows the carrier to make partial payment if a non-medically directed CRNA is involved in two concurrent cases involving student nurse anesthetists. The policy that allows payment to be made if a teaching CRNA is continuously present with a student nurse anesthetist is current policy that was included in the July 31, 1992 final CRNA fee schedule regulation, but was not specifically included in the Medicare Carriers Manual.

DISCLAIMER: The revision date and transmittal number only apply to the redlined material. All other material was previously published in the manual and is only being reprinted.

These instructions should be implemented within your current operating budget.

The conversion factors for anesthesia services furnished in 1992 by qualified anesthetists who are not medically directed were calculated using a 1992 base conversion factor of $15.75, except as noted below, and applying geographic practice cost indices similar to the method for medically directed conversion factors for 1992. If the 1990 nonmedically directed CRNA conversion factor was greater than $15.49 but less than $16.51, the 1992 conversion factor is the greater of the 1992 base conversion factor ($15.75) or the 1990 conversion factor. If the 1990 conversion factor was greater than $16.50, then the 1992 conversion factor is the 1990 nonmedically directed conversion factor reduced by 40 percent of the difference between the 1990 conversion factor and $16.50.

The base level conversion factor from subsection F is substituted above for $15.75, where noted, to determine the 1993, 1994, 1995, and 1996 nonmedically directed conversion factors. In addition, the reduction percentage of 40 percent in 1992 increases to 60 percent for 1993, to 80 percent for 1994 and to 100 percent for 1996. For example, if the 1990 nonmedically directed CRNA conversion factor was greater than $15.49 but less than $16.51, the 1994 conversion factor is the greater of $16.25 or the 1990 conversion factor. If the 1990 conversion factor was greater than $16.25, then the 1994 conversion factor is the 1990 nonmedically directed conversion factor reduced by 80 percent of the difference between the 1990 conversion factor and $16.50.

The conversion factor used to determine payments for anesthetists services cannot exceed the participating physician anesthesia conversion factor that is used to determine payment for physician anesthesia services for the same locality.

J. Anesthesia Services and Teaching CRNA. -- Payment can 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 (see Medicare Carriers Manual §4830). Full payment can not be made under Part B to a teaching CRNA who supervises two concurrent cases involving student nurse anesthetists. 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. You may allow payment, as follows, if a teaching CRNA is involved with two student nurse anesthetists:

- Recognize 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

- Recognize 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.

16004. NURSE MIDWIVES

See §2154 for coverage rules.

A. General.--Payment for nurse midwife services is equal to 80 percent of the lower of the actual charge or the nurse midwife fee schedule amount. The nurse midwife fee schedule amount for a particular service is equal to 65 percent of the participating physician fee schedule amount for the same service.

B. Special Payment Considerations.--Payment under the fee schedule for nurse midwife services and supplies is made only to the nurse midwife or to his or her employer. Payment must be made on an assignment basis. If assignment is not accepted, no payment may be made to the beneficiary for the services. Payment is equal to 80 percent of the lower of the actual charge or the fee schedule amount. Both coinsurance and the deductible are applicable to the service.

C. Global Allowances.--When a nurse midwife is providing care to a Medicare beneficiary and the collaborating physician provides some of the services, make sure that the fee paid to the nurse midwife is based on the portion of the global fee that would have been paid to the physician for the service provided by the nurse midwife.

For example, a nurse midwife requests that the physician examine the beneficiary, per their collaborative agreement, prior to the delivery. The nurse midwife has provided the ante partum care and intends to perform the delivery and post partum care. The physician fee schedule amount for the physician's total obstetrical care (global fee) is $1,000. The physician fee schedule amount for the physician's office visit is $30. The following calculation shows the maximum allowance for the nurse midwife's service:

Physician fee schedule amount for total obstetrical care	$1,000.00
Physician fee schedule amount for visit	- 30.00
	$ 970.00
Fee schedule amount for nurse midwife (65% x $970)	$ 630.50

Therefore, pay the nurse midwife no more than 80 percent of $630.50 for the care of the beneficiary.

This calculation also applies when a physician provides most of the services and calls in a nurse midwife to provide a portion of the care.

Physicians and nurse midwives use reduced service modifiers to report that they have not provided all the services covered by the global allowance.

D. Fee Schedule Update.--At the time of each update cycle, update the nurse midwife fee schedule by computing 65 percent of the new or updated physician fee schedule amount.

16005. EFFECT OF TRANSITION TO PHYSICIAN FEE SCHEDULE

Under the physician fee schedule, payment for a service is based on either a fee schedule amount or a transition amount. Each of the practitioner payments discussed in this chapter is linked to whichever amount (i.e., the physician fee schedule amount or the transition amount) is applicable and, therefore, serves as the basis for payment under the physician fee schedule. In effect, a transition amount, when in effect for a particular service, is the fee schedule amount for that service. For example, the nurse midwife fee schedule is 65 percent of the physician fee schedule amount. If the physician fee schedule amount for a service is $100 and the service is not subject to a transition amount, the nurse

midwife fee schedule amount is 65 percent of $100. If, on the other hand, that service is subject to a transition amount of $150, that amount constitutes the physician fee schedule amount for that service and the nurse midwife fee schedule amount is 65 percent of $150.

A. New Practitioner Payment Limits.--For services furnished on or before December 31, 1993, except as provided in subsection B below, the allowance for practitioners in their first four years of practice is limited to a percentage of the allowance for established practitioners. In the first year of practice, the practitioner's allowance is set at 80 percent of the allowance otherwise established for the service. For the second through fourth year of practice, the practitioner is limited to 85 percent, 90 percent, and 95 percent, respectively, of the allowance otherwise established for the service.

The first year of practice is defined as the first calendar year (and any partial year prior to the first calendar year) during which the practitioner has furnished professional services to Medicare patients for the 6-month period from January to June. (The first year of practice may include services billed to Part B on other than a fee-for-service basis, i.e., through a health maintenance organization or a provider.) The second, third, and fourth years of practice mean the first, second, and third calendar years, respectively, following the first year of practice as defined above.

The limits apply to all health care practitioners regardless of the practice setting (i.e., solo or group practice). The effective date for implementation of the limits is as follows:

- First year of practice (80 percent) limit is effective for services furnished on or after January 1, 1991; and

- Second, third, and fourth years of practice (85/90/95 percent) limits take effect in the first, second, and third calendar years, respectively, after 1991.

For example, a practitioner first begins practicing and billing Medicare in February 1991 for services payable under a fee schedule. Because of the January through June base period requirement, he or she is considered to be in the first year of practice through December 1992. Therefore, during 1991 and 1992, the fee schedule amount for the practitioner is limited to 80 percent of the fee schedule otherwise established for the service. In 1993, he or she is in the second year of practice and subject to the 85 percent limit.

NOTE: OBRA 1993 provides for the repeal of the new practitioner payment limits effective with services furnished on or after January 1, 1994. For services rendered in 1994 and thereafter, the reductions in payment for practitioners in the first four years of practice is repealed. However, see §5010.5 for determining the customary charge for new physician assistants and nurse practitioners.

B. Exemption to Limits for Practitioners in the First Through Fourth Year of Practice.--There are two exemptions to the payment limits for the professional services of practitioners in their first four years of practice. The exemptions cover the following services:

- Primary care services (see §15050.B); and

- Services rendered in a rural health professional shortage area (HPSA).

Rural areas are defined in §1886(d)(2)(D) of the Act. HPSAs are defined in §332(a)(1)(A) of the Public Health Service Act. The determination as to whether the service was rendered in a rural HPSA is based on where the service was performed rather than on the practitioner's billing address or office location. HCFA regional offices keep you informed of the specific rural areas in your jurisdiction that are designated as HPSAs.

16007. SCREEN RETENTION

During 1992, maintain in your system only the 1991 and 1992 fee screens for nonphysician practitioners. Pay for all services rendered in 1992 on the basis of the 1992 screens and for all services rendered prior to 1992 on the basis of the 1991 screens. In processing claims in 1993 and beyond, apply the screen in effect on the date the service was rendered. However, maintain in your system no more than two update or payment periods, i.e., maintain only the current screens and the immediately past screens. Therefore, if a service was rendered prior to the date that the immediately past payment screens were in effect and the claim is only just being processed, pay based on the immediately past screen.