Billing code invalid measure to identify nurse anesthetist stand-alone practice

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Nurse anesthetists often receive guidance from physician anesthesiologists, yet bill their time as if they are making decisions alone, according to a recent study of more than 9,000 cases published online in *Anesthesia & Analgesia*. The study suggests a frequently used billing code - called the modifier QZ - gives a false impression that many nurse anesthetists practice without the supervision of physician anesthesiologists.

"Our findings show that using the modifier QZ as a surrogate for nurse anesthetists working without the supervision of a physician anesthesiologist is incorrect," said Amr Abouleish, M.D., M.B.A., study co-author and professor of anesthesiology at the University of Texas Medical Branch, Galveston. "These findings invalidate the underlying premise of several previous studies that used the modifier QZ to determine how often nurse anesthetists provide unsupervised care. Therefore, the conclusions of those studies are not scientifically accurate."

Nurse anesthetists have two coding options for billing their clinical care for Medicare patients: modifier QX and QZ. The modifier QX is used in a very specific situation - when the physician anesthesiologist provides a high level of care to the patient. In contrast, modifier QZ is used in several different clinical situations including supervision of the nurse by physician anesthesiologist, supervision of the nurse by another physician, and the nurse working without supervision, as well as a high level of care with limited documentation. For the modifier QZ, it is impossible, based

on the above, to know from billing claims how care was provided.

In this study, investigators focused on 538 hospitals where 100 percent of the anesthesia claims -9,071 total - used the modifier QZ. Yet physician anesthesiologists were affiliated with 47.5 percent of these hospitals, representing more than 60 percent of the claims. Therefore, it is not valid to assume physician anesthesiologists had no role in the care of any patients, the authors note. According to the study, in situations when a nurse anesthetist is practicing and a physician anesthesiologist is also at the hospital, it is likely there is a formal working relationship that may include collaboration, consultation, rescue from critical events, or supervision. To put the findings of this study into perspective, while all claims for these hospitals were billed using the modifier QZ, nationally, less than 30 percent of anesthesia service Medicare FFS claims were billed using the modifier QZ in 2014.

"Our hypothesis was that if all of the nurse anesthetists' claims represented nurse 'solo' care in these facilities, then there would be no physician anesthesiologists working in these facilities," said Dr. Abouleish. "On the other hand, if there is a physician anesthesiologist at the facility, then he/she is providing care and the modifier QZ cannot be used to represent nurse 'solo' care."

Two previous studies(2,)(3,) which were designed with the underlying assumption that the modifier QZ represents nurse solo care, are often cited as evidence that this type of care is equivalent to care involving a physician anesthesiologist. Since this is not a correct assumption, it is impossible to know the impact of care provided by the nurse anesthetist on patient outcomes. Both studies drew from Medicare data files and focused on the type of provider involved in anesthesia care and the associated impact on surgical mortality and complications. The new findings raise serious concerns regarding the methodology of these studies, suggesting that they lack validity and their conclusions should

not be used to influence policy that may adversely affect patient care by allowing nurse anesthetists to administer anesthesia without being supervised by physician anesthesiologists.

"Anesthesia, the state of diseases of the patient, and the associated procedure have inherent risk," said Daniel J. Cole, M.D., American Society of Anesthesiologists president. "If we want to mitigate this risk, it is essential that the anesthesia team be led by a physician and, when seconds count, critical life and death decisions are made by a physician. Anesthesia is safer and more effective than ever in large part because of the enhanced education and training of physician anesthesiologists. Nurse anesthetists have an important role on the anesthesia care team, but it's essential to remember that patients want a physician to make critical decisions."

More information: "Anesthesiologists are Affiliated with Many Hospitals Only Reporting Anesthesia Claims Using Modifier QZ for Medicare Claims in 2013," *Anesthesia & Analgesia*, 2015.

Provided by American Society of Anesthesiologists