MEDICAL DIRECTION & ANESTHESIA CARE TEAM

Quick Reference Guide for Coders & Auditors

Core Principle: For Medicare payment at the medically directed rate, the physician must satisfy the applicable medical-direction requirements. Medical direction is not established merely because an anesthesiologist and a CRNA/AA both participated in the case.

1. What Is the Anesthesia Care Team (ACT)?

The anesthesia care team describes anesthesia care involving an anesthesiologist working with other qualified anesthesia personnel.

- Team composition may include anesthesiologists, CRNAs, anesthesiologist assistants (AAs), residents, student nurse anesthetists, or other qualified individuals as permitted by applicable law, regulation, and payer requirements.
- The clinical concept of an anesthesia care team does not automatically determine the Medicare payment category or modifier selection.
- For coding and auditing, identify who furnished the anesthesia service, the physician's level of involvement, the available concurrency determination, documentation supporting the service, and the applicable payer requirements.

2. Medicare's Seven Medical-Direction Requirements

#	Requirement	Medicare Medical-Direction Activity
1	**Pre-anesthetic examination & evaluation**	Physician performs the pre-anesthetic examination and evaluation.
2	**Prescribe the anesthesia plan**	Physician prescribes the anesthesia plan.
3	**Participate in the most demanding procedures**	Physician personally participates in the most demanding procedures in the anesthesia plan, including induction and emergence when applicable.
4	**Ensure qualified performance**	Physician ensures procedures in the anesthesia plan that the physician does not personally perform are performed by a qualified individual.
5	**Monitor at frequent intervals**	Physician monitors the course of anesthesia administration at frequent intervals.
6	**Remain physically present & available**	Physician remains physically present and available for immediate diagnosis and treatment of emergencies.
7	**Provide indicated post-anesthesia care**	Physician provides indicated post-anesthesia care.

Chart Talk Audit Alert: Medicare medical direction is based on the complete set of required physician activities. Do not limit review to selected elements simply because they are easier to identify in the anesthesia record. When a required element is not supported, additional review may be necessary before concluding that the service qualifies for payment at the medically directed rate.

3. Medical Direction vs. Other Medicare Payment Categories

Medicare Payment Category	Modifier(s)	Quick Meaning
Personally Performed	AA	Anesthesia services personally performed by the anesthesiologist.
1 Medically Directed Case	QY (physician) + QX (qualified nonphysician anesthetist)	Anesthesiologist medically directs one qualified nonphysician anesthetist.

Medicare Payment Category	Modifier(s)	Quick Meaning
2-4 Concurrent Medically Directed Cases	QK (physician) + QX (qualified nonphysician anesthetist)	Physician medically directs two, three, or four concurrent anesthesia procedures involving qualified individuals.
Medical Supervision	AD (physician)	Physician medical supervision of more than four concurrent anesthesia procedures.
CRNA Without Medical Direction	QZ (CRNA)	CRNA service without medical direction by a physician.

4. Concurrency: Why It Matters

- Medicare medical direction generally applies to one through four concurrent anesthesia procedures when the applicable medical-direction requirements are satisfied.
- QY identifies medical direction of one qualified nonphysician anesthetist; QK identifies medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals.
- In many coding environments, concurrency is determined through system logic or another established workflow rather than manually calculated by the coder.
- Coders and auditors should understand the concurrency rules so they can recognize situations that appear inconsistent with the reported medical-direction category or modifier.
- When concurrency must be reviewed, overlapping non-Medicare anesthesia cases may also affect the Medicare concurrency determination; follow the applicable Medicare and organizational workflow.
- Medical supervision (AD) applies when the physician is medically supervising more than four concurrent anesthesia procedures.

Chart Talk Audit Consideration: Even when concurrency is calculated behind the scenes, unusual overlaps, provider assignments, modifier combinations, or other inconsistencies may warrant additional review.

5. Medical-Direction Documentation & Audit Review

CMS Documentation Focus: Review the record for documentation supporting the physician's required medical-direction activities, including the physician's pre-anesthetic examination and evaluation, participation in the most demanding procedures when applicable, monitoring involvement, and indicated post-anesthesia care.

Chart Talk Audit Review: In addition to CMS's expressly stated documentation expectations, review the complete anesthesia record and relevant circumstances for support that all applicable medical-direction requirements were satisfied.

- Physician prescription of the anesthesia plan.
- Performance of procedures not personally performed by the physician by a qualified individual.
- Monitoring of anesthesia administration at frequent intervals.
- Required physician physical presence and availability for immediate diagnosis and treatment of emergencies.
- Provider identities and anesthesia start/stop times sufficient to review or validate concurrency when necessary.
- Appropriate signatures, attestations, and authentication under applicable documentation requirements.

Group Practice Note: Medicare permits different physician members of the same anesthesiology group to furnish certain components of the medically directed service. The medical record must indicate that the services were furnished by physicians and identify the physicians who furnished them.

6. Chart Talk Medical-Direction Audit Red Flags

Chart Talk Audit Consideration: The following findings do not automatically mean that medical direction was not performed or that a claim is incorrect. They indicate that additional review may be necessary before concluding that the service qualifies for Medicare payment at the medically directed rate.

- No documentation supporting the physician's performance of the pre-anesthetic examination and evaluation.
- No support that the physician prescribed the anesthesia plan.
- Insufficient documentation supporting physician participation in the most demanding procedures, including induction and emergence when applicable.
- No support that procedures not personally performed by the physician were performed by a qualified individual.
- Missing or insufficient evidence of physician monitoring at frequent intervals.
- Documentation or circumstances raising questions about the physician's required physical presence and immediate availability.
- Missing documentation of indicated physician post-anesthesia care.
- Overlapping anesthesia cases that may exceed the permitted medical-direction concurrency level.
- Anesthesia/provider times that conflict or do not reasonably align with the documented clinical sequence.
- Generic, cloned, or repetitive attestations that do not reasonably align with the individual patient's clinical record or timeline.
- QK, QY, or QX selected solely because the facility uses an anesthesia care-team staffing model, without verifying that Medicare's medical-direction requirements were satisfied.

7. Chart Talk Quick Medical-Direction Audit Workflow

Step	Action	Review
1	**Identify the Team**	Determine who furnished the anesthesia service and each provider's role.
2	**Map the Time**	Establish anesthesia start/stop times and identify relevant overlaps.
3	**Review Concurrency**	Review the concurrency determination available within the applicable system or workflow and identify discrepancies or circumstances requiring further review.
4	**Test All 7 Elements**	Confirm that each required medical-direction activity is supported.
5	**Check Availability**	Review other services or activities that could affect required physical presence and immediate availability.
6	**Validate Modifiers**	Confirm that the reported AA, AD, QK, QY, QX, or QZ modifier is supported by the documented circumstances.
7	**Apply Payer Policy**	Do not assume Medicare rules apply identically to Medicaid or commercial payers.
8	**Document Findings**	Maintain a clear audit trail for exceptions, queries, modifier changes, or other actions taken.

Chart Talk Note: This workflow is an educational audit framework designed to organize the review process. It is not an official CMS-required sequence.

8. Coder's Bottom Line

Medical direction is a Medicare payment and documentation standard, not simply a description of an anesthesia care-team staffing model. For Medicare, determine whether the documentation supports the applicable medical-direction requirements, review the reported payment modifiers, and understand the concurrency determination used within the organization's established workflow.

Do not assume a required medical-direction activity was performed simply because it is customary for the anesthesia care team. When documentation or other information raises a question about whether a

requirement was satisfied, follow the appropriate review, query, escalation, or compliance process before determining the supported billing category.

Authoritative Resources & References

- Centers for Medicare & Medicaid Services (CMS). Medicare Claims Processing Manual, Pub. 100-04, Chapter 12, §50 - Payment for Anesthesiology Services, including personally performed, medically directed, and medically supervised payment rules and anesthesia claims modifiers.
- Centers for Medicare & Medicaid Services (CMS). Anesthesiologists Information Center - current Medicare anesthesia billing, payment, manual, and regulatory resources.
- Centers for Medicare & Medicaid Services (CMS). Current CRNA/APRN and Anesthesiologist Assistant (AA) payment and billing guidance, as applicable to provider type and service.
- Centers for Medicare & Medicaid Services (CMS). Medicare NCCI Policy Manual, Chapter 2 - Anesthesia Services, CPT Codes 00000-01999. 2026 edition, effective January 1, 2026.
- Applicable federal regulations, state scope-of-practice requirements, Medicare Administrative Contractor (MAC) guidance, Medicaid policy, commercial payer policy/contracts, and organizational requirements, as applicable.

Source Verification Note: Authoritative guidance should be reviewed in its current version. Coding, billing, documentation, supervision, scope-of-practice, and reimbursement requirements may change and may vary by payer, jurisdiction, provider type, and setting.

Educational Use Only

This quick reference is intended for coding and auditing education. It does not replace current CPT® , CMS, MAC, Medicaid, commercial payer, state, organizational, contractual, legal, or compliance guidance. The inclusion or discussion of a modifier, service, methodology, or billing concept does not guarantee coverage or reimbursement.