Anesthesia Modifiers: The Cheat Sheet

What each Medicare anesthesia modifier means, who bills it and what it pays, with the rules that most often turn a clean claim into a recoupment. Medical direction's seven conditions are on page 2.

01 How Medicare pays an anesthesia case

> **(base units + time units) × anesthesia conversion factor**, adjusted for locality. A time unit is 15 minutes; partial units count as fractions rounded to one decimal. 2026 national conversion factor: **$20.4976** ($20.5998 for qualifying APM participants). Proposed for 2027: $20.2143 and $20.4165.

02 Payment modifiers

CODE	MEANING	BILLED BY	MEDICARE PAYS
AA	Anesthesia personally performed by an anesthesiologist	Anesthesiologist	**100%**
QK	Medical direction of two, three or four concurrent procedures	Anesthesiologist	**50%**
QY	Medical direction of one CRNA	Anesthesiologist	**50%**
QX	CRNA or anesthesiologist assistant service with medical direction by a physician	CRNA or AA	**50%**
QZ	CRNA service without medical direction by a physician	CRNA	**100%**
AD	Medical supervision of more than four concurrent procedures, or directing while performing other services	Anesthesiologist	**3 base units** **+1 time unit if present at induction**

- **Concurrency counts every patient.** The two-to-four limit for QK includes patients of all payers, not just Medicare patients.
- **QZ is for CRNAs only.** An anesthesiologist assistant must always be medically directed and bills QX.
- **AA and QZ on the same case** are both paid in full only when both clinicians were medically necessary and both document their involvement.
- **Under AD** the CRNA typically still bills QX for half the fee (check your contractor's guidance); only the anesthesiologist's side is capped.

03 One 9-unit case, four ways

HOW THE CASE WAS COVERED	ANESTHESIOLOGIST	CRNA	TOTAL
Personally performed (AA)	$184.48	—	$184.48
CRNA alone, no medical direction (QZ)	—	$184.48	$184.48
Medical direction (QK or QY, with QX)	$92.24	$92.24	$184.48
Medical supervision (AD, with QX)	$81.99 at most	$92.24	$174.23

5 base units + 60 minutes (4 time units) at the 2026 national conversion factor, before locality adjustment. Supervision caps the anesthesiologist at four units, so it pays less on every case longer than about 8 units.

04 Informational modifiers

QS	Monitored anesthesia care (MAC). Paid on base and time units like other anesthesia; still needs a payment modifier.
G8	MAC for a deep, complex, complicated or markedly invasive surgical procedure
G9	MAC for a patient with a history of a severe cardiopulmonary condition
GC	Service performed in part by a resident under a teaching physician's direction

These go in the second position, after a payment modifier. They describe the service; they do not change the rate.

05 Also worth knowing

- **P1–P6 physical status:** Medicare adds no units for them. Some commercial payers do.
- **Teaching anesthesiologists** are paid in full (AA with GC) for one resident case, two concurrent resident cases, or one resident case alongside one medically directed CRNA or AA case, when present for all critical or key portions and an anesthesiologist is immediately available (42 CFR 414.46(e)).
- **The commercial 85% rule:** on their commercial plans, UnitedHealthcare (from October 2025), Cigna (from 2023) and Anthem in some states (from November 2024) pay QZ claims at 85%. Medicare still pays QZ at 100%.

Medical Direction: The Seven Conditions

To bill QK or QY, the anesthesiologist must meet all seven conditions of 42 CFR 415.110 for every patient. Miss one and the case is not medical direction: depending on what went wrong and the contractor, it becomes supervision (AD), a CRNA-only claim, or not payable at all.

06 Check each directed case

THE ANESTHESIOLOGIST MUST	WHAT THE RECORD SHOULD SHOW
☐ **1 Perform a pre-anesthetic examination and evaluation**	The anesthesiologist's own pre-anesthetic note
☐ **2 Prescribe the anesthesia plan**	The plan, attributed to the anesthesiologist
☐ **3 Personally participate in the most demanding procedures, including induction and emergence**	Presence at induction and emergence, at times that do not clash with the other rooms being directed
☐ **4 Ensure anything they do not perform is done by a qualified individual**	Who performed each part the anesthesiologist did not
☐ **5 Monitor the course of anesthesia at frequent intervals**	Presence during part of the maintenance phase
☐ **6 Remain physically present and available for emergencies**	Concurrency of four or fewer and no absences from the suite
☐ **7 Provide indicated post-anesthesia care**	The anesthesiologist's post-anesthesia note

The physician, not the CRNA, documents the pre-anesthetic exam, the post-anesthesia care and presence at the most demanding procedures. Within a group, a different anesthesiologist may do the pre- or post-anesthesia work if the record says who.

07 Limits

- **No more than four** concurrent procedures, counting patients of every payer.
- **No other services** that would cause any of the seven to be missed. More than four cases, or other services while directing, is supervision (AD).
- **Leaving the immediate area** of the operating suite for more than short periods, or spending extended time on an emergency, means the cases do not qualify for the medically directed rate.

08 Allowed while directing

- An emergency of short duration in the immediate area
- An epidural or caudal anesthetic to ease labor pain
- Periodic, rather than continuous, monitoring of an obstetric patient
- Receiving patients entering the operating suite for the next surgery
- Checking on or discharging patients in the recovery room
- Handling scheduling matters

09 Where claims go wrong

- QK billed when one of the seven conditions was missed
- Concurrency counted on Medicare patients only
- Directing while doing work outside the allowed list
- QS, G8 or G9 sent without a payment modifier
- Commercial habits applied to Medicare, such as units for physical status
- Teaching cases billed under pre-2010 rules, or without documented presence for key portions

Audit exposure. Medicare contractors sample-review medically directed claims. A physician who cannot produce the documentation can be required to submit it with every later claim, and cases billed as directed that were not are overpayments that can be taken back.

Want a sample of your directed cases checked against these rules?
We review modifiers, concurrency and the record behind them, and show where claims are exposed or under-billed.

anesthesiaoperationsconsultants.com/contact
(561) 674-1825

Sources: 42 CFR 414.46, 414.60 and 415.110; CMS Medicare Claims Processing Manual, chapter 12, sections 50, 100 and 140; CMS MLN006347, Guidelines for teaching physicians, interns and residents; CY 2026 Physician Fee Schedule final rule. A general reference to Medicare rules as of October 2026, not legal or billing advice: check your Medicare contractor's guidance and each payer's policy.