Anesthesia Billing: 101

Presented by: Medi-Corp, Inc
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Complete documentation ensures Maximum Reimbursement

- Date of Service
- Patient's name
- Patient's age
- Patient's gender
- Patient's diagnosis
- Specific procedure performed
- Diagnosis to support medical necessity of anesthesiologist
  - ☞ *Unacceptable diagnosis are: rule out, suspected, possible, vs., and status post*
- Patient's physical status (P_1-P_3)
- The type of anesthesia provided: General, Regional or MAC
- Position whether prone or supine
- Start and end time for anesthesia care
- Documentation of discontinuous time
- Documentation of anesthesiologist relieving other anesthesiologist
- Documentation of surgeon's request for post-op pain management

Key Point: ANESTHESIA RECORDS CAN NOT BE PRE-SIGNED

Anesthesia Record Documentation Requirements

Patient's name

- ***The name must be the same as it appears on their insurance card***

Patient's age

- ***If the patient is a child under 1 year, the age should include months, so a child 10 months old would not be mistaken for 10 years old.***

Patient's diagnosis

- ***Unacceptable diagnoses: rule out, suspected, possible, vs., and status post***
- ***Acceptable diagnoses: admitting diagnosis, post-operative diagnosis or symptoms***

Note: Systemic conditions to support medical necessity for MAC procedures, such as cardiopulmonary disease, and psychological condition such as dementia

Procedures performed

- ***Record should have specific procedure(s) performed***

  Ex: arthroscopic procedures that are not diagnostic should have specific surgical arthroscopic procedure

  Key Point: ***Coordinate anesthesia billing with the surgeon and document other procedures performed such as lines or post-op pain blocks***

Documentation Requirements Cont..

- **Patient's physical status (P_1-P_5)**

For physical status P_3-P_5, a diagnosis is necessary with the systemic condition supporting the status.

Ex: cardiopulmonary disease and psychological condition such as dementia

- **The type of anesthesia provided: General, Regional, MAC, Spinal**

TIVA is how physician administers drug, not the level of anesthesia obtained

Key Point: **Local anesthesia and standby are not payable**

- **Field Avoidance**

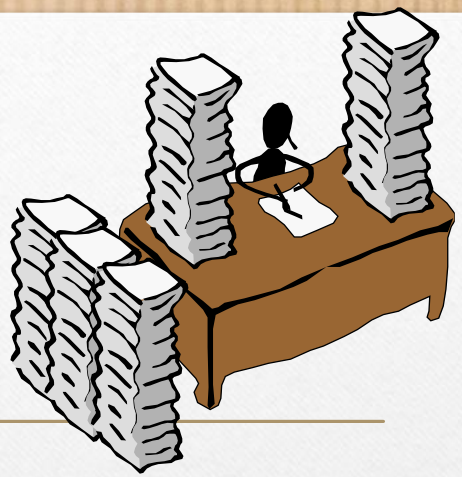
Any procedure requiring field avoidance has a base unit value of 5, regardless of any lesser value assigned to the procedure. **Ex: ear tube is 4 base units; field avoidance will raise it to 5**

Note: Medicare and Medicaid does not reimburse for field avoidance

- **Position**
- **Procedures in the prone position have a base unit of 5 regardless of any lesser value assigned to the procedure.**
- **Prone position must be documented.**

Note: Medicare and Medicaid does not reimburse for position

Anesthesia Start Time



The Code of Federal Regulations states:

"Time units involve the continuous actual presence of the physician (or the medically directed qualified anesthetist or resident) and starts when he or she begins to prepare the patient for anesthesia care"

Preparing the patient for anesthesia is the insertion of an IV to administer Versed or the administration of pre-op medication

The start time listed on the record must corroborate with documentation on the graph. This can be the documentation of vitals

Anesthesia End Time

"Anesthesia care ends when the anesthesiologist (or medically directed CRNA) is no longer in personal attendance, that is, when the patient may be safely placed under post-operative care."

Key Point: Start and stop times must be listed in exact minutes – Do Not document time in 5 minute increments

Relief Time Documentation

- **Documentation must show when one anesthesiologist relieves another, especially when medically directing.**

- **The first anesthesiologist's start time should match the anesthesia start time on the record.**

- **The first anesthesiologist should mark the time he passes off medical direction to another anesthesiologist.**

- **The second anesthesiologist documents the time he assumes the case.**

COMMON RELIEF MISTAKES

- ***A medically directing anesthesiologist cannot give a CRNA a lunch or bathroom break as a CRNA must be present the entire case. The anesthesiologist would be personally performing the case without the presence of a CRNA and you cannot personally perform when you are medically directing other cases.***

Key Point: ***You would only be able to bill the above case the time that the CRNA was present.***

Relief continued:

Another problem would be an anesthesiologist personally performing a case and a CRNA taking over. That would change to medically directing.

To avoid these problems a CRNA should relieve a CRNA

An anesthesiologist should relieve an anesthesiologist

Physicians in the Same Group

When one anesthesiologist of the same group takes over for another anesthesiologist, the case can be billed in one of two ways; provider who started the case or the one with the most time spent on the case

The pre-anesthesia or post – anesthesia portion of the case can be performed by one MD and the other components of the anesthesia care performed by another in the group.

Key Point: The Anesthesia Record MUST indicate the start and end time of each anesthesiologist.

DISCONTINUOUS TIME

Example: Cataract procedure

Anesthesiologist does MAC portion for the surgeon doing a retrobulbar block

Anesthesiologist is not present during 30 minutes while block is taking effect

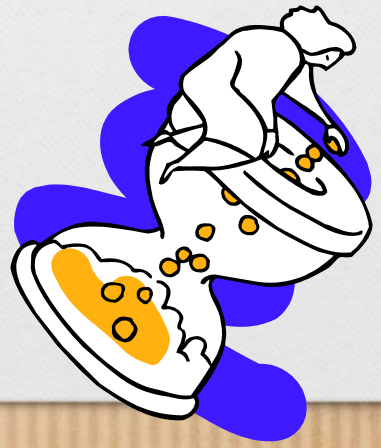
- **Anesthesiologist resumes monitoring in OR during the extraction**

Documenting Time:

Add the total minutes of MAC for the block and total of OR time

Document the start and end time of each portion on the anesthesia record

- ***For cataract cases without a CRNA the anesthesiologist cannot charge for the anesthesia time if he isn't present for the entire time of the extraction. If he is handling more than one case and administering the block, then he can opt to just bill for the block.***



Cancelled Anesthesia Cases

- **Billing for a cancelled anesthesia procedure depends on when the procedure was cancelled.**
- **If a case was cancelled after the pre-op but before the patient is prepared for surgery, use evaluation and management codes**

Key Point: ***You must relate the codes to the specific place of service code.***

- **If a case was cancelled after the patient has been prepared for surgery, but before induction, bill 3 base units.**
- **If cancelled after induction you can bill the base units and full anesthesia time.**

Lack of PACU documentation = LOSS OF REVENUE

- **Anesthesia time does not end when the patient enters PACU**
- **PACU time is billable until the patient can be safely turned over to post-anesthesia care**
- **Document vital signs taken in PACU**
- **If time is over 15 minutes include documentation stating the reason on the anesthesia record.**
  ex: placement of PCA

Key Point: ***Do not add time for placement of lines that are billed as surgical procedures.***

PACU IN – when patient enters PACU
PACU OUT – when the patient is turned over to post-anesthesia care

Advisable to document on record:
"Patient turned over to recovery 07:15"

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Procedures done in the Pre-OP area and PACU

Epidural Catheters	Placement of Lines	Start of
Providers CANNOT BILL time for epidural catheters placed in the pre-op if its for post-op pain management	Providers CANNOT BILL TIME for A-Lines, CVPs or Swan-Ganz Placement of lines is a surgical procedure and will be billed out as (1) unit. These procedures are based on a flat fee.	PCA is considered routine post-op pain management and is NOT BILLABLE.
Providers **CAN BILL TIME** for placement of the epidural catheter in the pre-op area if it is the method of anesthesia	Anesthesia time will not be deducted if the lines are placed during the anesthesia time.	A provider setting up the PCA in PACU CAN count it as anesthesia time. Document the request from the Surgeon.

Qualifying Circumstances

99100	• Anesthesia for patients of extreme age, < 1year and > than 70 years old
99116	• Complicated by utilization of total body hypothermia
99135	• Complicated by utilization of controlled hypotension
99140	• Complicated by emergency conditions

Billing Lines

Medicare will reimburse non-medically directed CRNAs for line placement
Medicare will allow the anesthesiologist to bill for the placement of line done by a medically directed CRNA

Your documentation must show that the provider actually placed the line in order to justify billing for the procedure

***Key Point:* Merely checking a box is not enough.**

Document the following:

- ✓Initial to indicate which provider performed the services
- ✓Document if any lines were placed by the surgeon
- ✓Document the time the line was placed

Arterial Catheter = 36620

Central Venous Catheter = 36555/36556

Pulmonary Artery(Swan-Ganz) Catheter = 93503

7 Steps to Medical Direction

To be covered for medical direction by Medicare, the anesthesiologist must:

1. Perform and document the pre-anesthesia examination and evaluation
2. Prescribe and document the anesthesia plan
3. Take part personally in the most demanding portion of the anesthesia plan, including induction and emergence
4. Ensure that a qualified anesthetist performs procedures in the anesthesia plan that he doesn't perform.
5. Monitor the course of the anesthesia administration at intervals
6. Be physically present and available for immediate diagnosis and treatment of emergencies.
7. Provide the post-anesthesia care

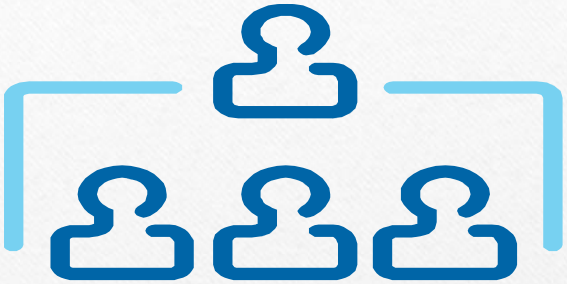
MAC cases do not require that the anesthesiologist be present for induction and emergence.

Medical Direction: **Reimbursement is equivalent to a procedure personally performed: Payment distribution is 50/50**

Medical Supervision: **Reimbursement is 3 base units x CF for MD and total time & base x CF at 50% for the CRNA**

***** one additional base unit allowed for MD induction***

Billing Alert



GENERAL

Anesthesiologist must be present for the

INDUCTION AND EMERGENCE

MAC CASES

Anesthesiologist does not have to be present for induction and emergence

Should Periodically check patient 1st ten minutes to see if case turns to General Anesthesia

BROKEN MEDICAL DIRECTION

If the physician must leave the immediate area for other than a short duration or devotes extensive time to an emergency case or is otherwise not available to respond to the surgical patients; the services provided by the physician are now considered "Supervisory" not "Medically Directed".

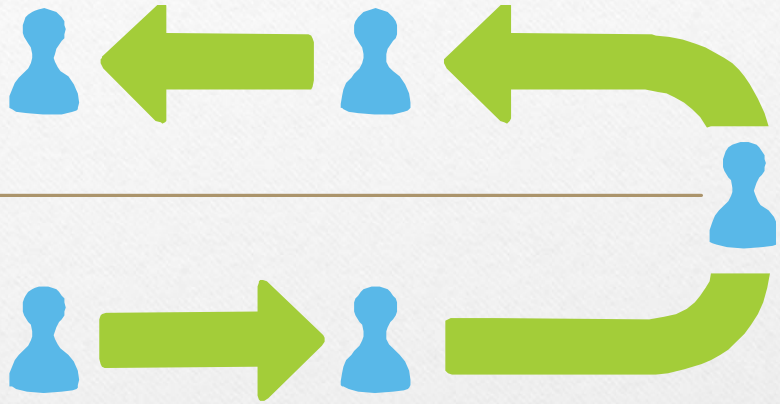
Supervision Definition: More than 4 concurrent anesthesia procedures

Medicare only allows three base units per procedure when the anesthesiologist is involved in more than 4 procedures concurrently or is performing other services while directing the concurrent procedures.

An additional time unit may be recognized if the physician can document he or she was present at induction. *CMS Chapter 12, Claims Processing Manual.*

Key Point: Medicare clarification of concurrency is when the starting point of one anesthesia procedure and the ending point of a second anesthesia procedure are the same.

Examples of Breaking Medical Direction



- **CASE** #1 -07:16-08:22 **Medically Directed**
- **CASE** # 2 -07:36-08:50 **Personally Performed**
- **CASE** #3 – 08:39-09:35 **Medically Directed**

- **2nd CASE – when an Anesthesiologist is PERSONALLY PERFORMING a case He / She cannot be involved in any other case/situation**
- **Cases sharing the same minute is considered concurrency for medical direction purposes**

- **Medicare will consider all concurrent cases when performing an audit…**

Documentation of Medical Direction on Anesthesia Record

Source: CMS Manual System; Pub 100-04 Medicare Claims Processing: "Rules for Medical Direction – 1:4 "

The physician must participate only in the most demanding procedures of the anesthesia plan, including, if applicable, induction and emergence. Physicians must document in the anesthesia record that he or she performed the pre-anesthetic examination and evaluation, and indicate that they provided post-anesthesia care, present during some portion of the anesthesia monitoring.

The physician can medically direct two, three or four concurrent procedures, all of whom can be CRNAs.

Key Point: CMS expects that the anesthesiologist personally perform and document all seven requirements for medical direction.

Interpretative Guidelines for "Immediately Available"

IGs and CoP (conditions of participation) for Hospitals defined "immediately available for Physicians and supervision of CRNAs. The latest revision is dated 1/14/11 and concludes the following:

Immediately available is defined as, "the medically/supervising physician is physically located within the same area as the CRNA, e.g., in the same operative/procedural suite, or in the same labor and delivery unit, and not otherwise occupied in a way that prevents him/her from immediately conducting hands-on intervention, if needed"

In other words, you should not supervise CRNAs located in two different areas of the hospital.

It is important to understand that if a sedation is considered "anesthesia" vs. Analgesia, then an anesthesiologist must be physically in the area to supervise that CRNA, and cannot be involved at same time in supervising other CRNAs who are not in the L&D suite.

Good News for Labor Epidural Supervision:

CMS has removed language specifically exempting labor epidurals from the physician supervision requirements. Hospitals are now required to "establish policies and procedures, based on nationally recognized guidelines, that address whether specific clinical situations involved anesthesia versus analgesia," as well as, "the minimum qualifications and supervision requirements for each category of practitioner who is permitted to provide analgesia services."

Physician Quality Reporting System

Measure #30 Perioperative Care: Timely Administration of Prophylactic Parenteral Antibiotics

Numerator codes (CPT II)

- 4048F – Antibiotic was administered within one hour prior to surgical incision, as ordered
- 4048F – 1P – Medical reasons for not initiating administration of antibiotics as specified
  (e.g. contraindicated, patient already receiving antibiotics)
- 4047F – 8P – No documentation of order for antibiotics to be given with one hour prior to incision
- 4048F – 8P – Antibiotic was not initiated within one hour prior to incision – reason not otherwise specified

Measure #76: Prevention of Catheter- *Related Bloodstream Infections:* Central Venous Catheter insertion Protocol

- *Sterile condition Definition:* Use of all; cap, mask, sterile gown, gloves, large sterile sheet, hand hygiene and 2%c chlorhexidrine for cutaneous antisepsis.

Numerator codes (CPT II)

- 6030F – All elements of sterile technique met
- 6030F – 1P – Medical reasons for not following all sterile techniques during CVC insertion
  (e.g. insertion performed on emergency basis)
- 6030F – 8P – Sterile technique not followed, reasons not specified

Measure #193 Perioperative Temperature Management: Active warming was used intraoperatively

Anesthesia time used for this measure should be the time recorded in the anesthesia record excludes patients undergoing Cardiopulmonary bypass

- Numerator codes (CPT II)
- 4250F – Active warming used intraoperatively and recorded 30 minutes immediately before or 15 minutes immediately after anesthesia end time

  AND
- 4255F – General or neuraxial anesthesia 60 minutes or longer, as documented in the anesthesia record
- 4250F – 1P – Intentional hypothermia or active warming not indicated due to anesthetic technique: PNB without general anesthesia or MAC

  AND
- 4255F- 60 minutes or longer
- 4256F – Duration of general or neuraxial anesthesia is less than 60 minutes
- *This numerator is to be used when patient does not meet denominator based on time, and anesthesia technique is via MAC or PNB – Only one numerator is required*
- 4250F-8P – Active warming not performed within designated time frame or reason not otherwise specified

  AND
- 4255F – 60 minutes or longer

Acute Pain Management
Post-Op Blocks

Acute pain management is considered part of the Surgeon's global package.
The anesthesiologist must have a request from the Surgeon to bill.

The following documentation is required:

- **Request from the Surgeon**
- **Diagnosis supporting the procedure**
- **Procedure notes**

Specify whether the post-op management is placement of a catheter, a single injection or continuous infusion

Epidural catheter for post-op pain is billable the day of insertion and 3 subsequent days

Guidelines for Amended Records

Incomplete or illegible records can result in denial of payments, overpayment or considered a fraudulent claim.

A valid claim must have sufficient documentation on the Anesthesia Record to verify that the services were "reasonable and necessary".

Types of Amended Records

Late Entry: A late entry indicates additional information that was omitted from the original entry. The late entry **bears the current date,** is added as soon as possible, is written only if the person documenting has total recall of the omitted information and signs or initials the late entry.

Addendum: An addendum is used to provide information that was not available at the time of the original entry. The addendum should also **be timely and bear the current date and reason for the addition or clarification of information being added to the medical record and be signed or initialed by the person making the addendum.**

Correction: When making a correction to the medical record, never write over, or otherwise obliterate the passage when an entry to a medical record is made in error. Draw a single line through the erroneous information, keeping the original entry legible. Sign and date the deletion, stating the reason for correction above or in the margin. **Document the correct information on the next line or space with the current date and time, making reference back to the original entry.**

Examples of amended records

- **Late Entry:** Missing signature, date of service, "recorded on date of service". Corrected prior to claim submission
- **Addendum:** Reviewing additional records such as x-ray reports, Indicating additional line placement, blocks, presence of a provider not originally indicated on record (concurrency)
- **Correction:** Incorrect date of service indicated on Anesthesia Record, Incorrect start and end time

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Falsified documentation is considered a felony offense.

Examples:

Creation of new records when records are requested

- Back-dating entries
- Post-dating entries
- Pre-dating entries
- Writing over, or
- Adding to existing documentation (except as described in late entries, addendums and corrections)

Sources: Section 1933(e) Title XVIII of the Social Security Act (no Documentation); Section 1842(a) (1) (c) of the Social Security Act (Carrier Audits); Section 1862(a) (1) (A) of Title XVIII of the Social Security Act (Medical Necessity)

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