Billing & Compliance for Anesthesia Services

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Anesthesia Billing

- Anesthesia is a Unique Specialty
- ASA* vs. CPT codes
- Anesthesia Specific Modifiers
- Time based Billing

*ASA = American Society of Anesthesiologists

Overview

- Components of Anesthesia Billing
- Documentation Requirements
- Operational Challenges in Meeting Documentation Requirements

Formula for Anesthesia Services Billing & Reimbursement

(Base Units + Time Units*) X Conversion Factor

=

Billed Amount or Reimbursement Amount

*Time Units = Duration of case in minutes / 15 minutes

Billing with Anesthesia Time

- Base units are determined by the procedure code. (May vary per carrier).
- Time units are calculated in 15 minute increments for Government carriers (may be negotiated differently for managed care contracts).
- Conversion Factor is a dollar amount determined by the anesthesia group to bill and by the carrier/carrier contract to determine reimbursement.

Specific Modifiers for Anesthesia Services

Billed amount or reimbursement is adjusted by modifiers specific to the specialty and according to the following concurrency types:

- Personally Performed (AA modifier)
- Concurrent Medical Direction (QY, QK, modifiers)
- Medical Supervision (AD modifier)

Medical Direction Vs. Medical Supervision

- Medical Direction is up to four concurrent anesthesia procedures.
- Medical Supervision is more than four concurrent anesthesia procedures.

No Concurrency (Personally Performed)

- Anesthesiologist personally provides anesthesia services to single patient
- Continuously present
- No “hands-on” care to other patients

This staffing model is used at CMC

Concurrent Medical Direction

Anesthesia Team Care Model

- Up to four CRNAs 1:1 - 1:4
- Two residents (per ABA guidelines) 1:2
- One resident/one CRNA (per ABA guidelines) 1:2
- Two SRNAs 1:2
- If one time unit overlaps and ratio exceeds 1:4 - none of the cases are billable as medical direction

This staffing model is used at University Hospital Zale, St. Paul, and the VA

Medicare Rules of Medical Direction

To meet the requirements of medical direction of residents/fellows/ CRNAs, the staff anesthesiologist must <u>follow</u> and <u>document</u> these 7 steps:

1. Perform the pre-anesthetic exam and evaluation;
2. Prescribes the anesthetic plan;
3. Personally participate in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence;
4. Ensure that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual;
5. Monitors the course of anesthesia at frequent intervals;
6. Remain physically present and available for immediate diagnosis and treatment of emergencies; and
7. Provide indicated post-anesthesia care.

Medical Supervision

- No requirement to personally perform most demanding portions of the case.
- Five to seven CRNAs 1:5 – 1:7
- Maximum reimbursement to MD is 3 base units.
- No time units are reimbursable.
- One additional unit may be reimbursable if documentation supports the presence of the MD during induction.
- No requirement for involvement in post anesthesia care.

Other Anesthesia Services

- Receives patients entering the operating suite for next surgery
- Checks on or discharges patients from recovery room
- Coordinates scheduling matters

System of Checks and Balances

- Reconcile anesthesia records with anesthesia logs and operating room schedules
- Batch anesthesia record with operating room worksheet
- Confirm seven steps of medical direction
- Physician Returns
- Daily/Monthly/Quarterly Internal Audit
- Annual external audit

The Billing Office's Role in Compliance

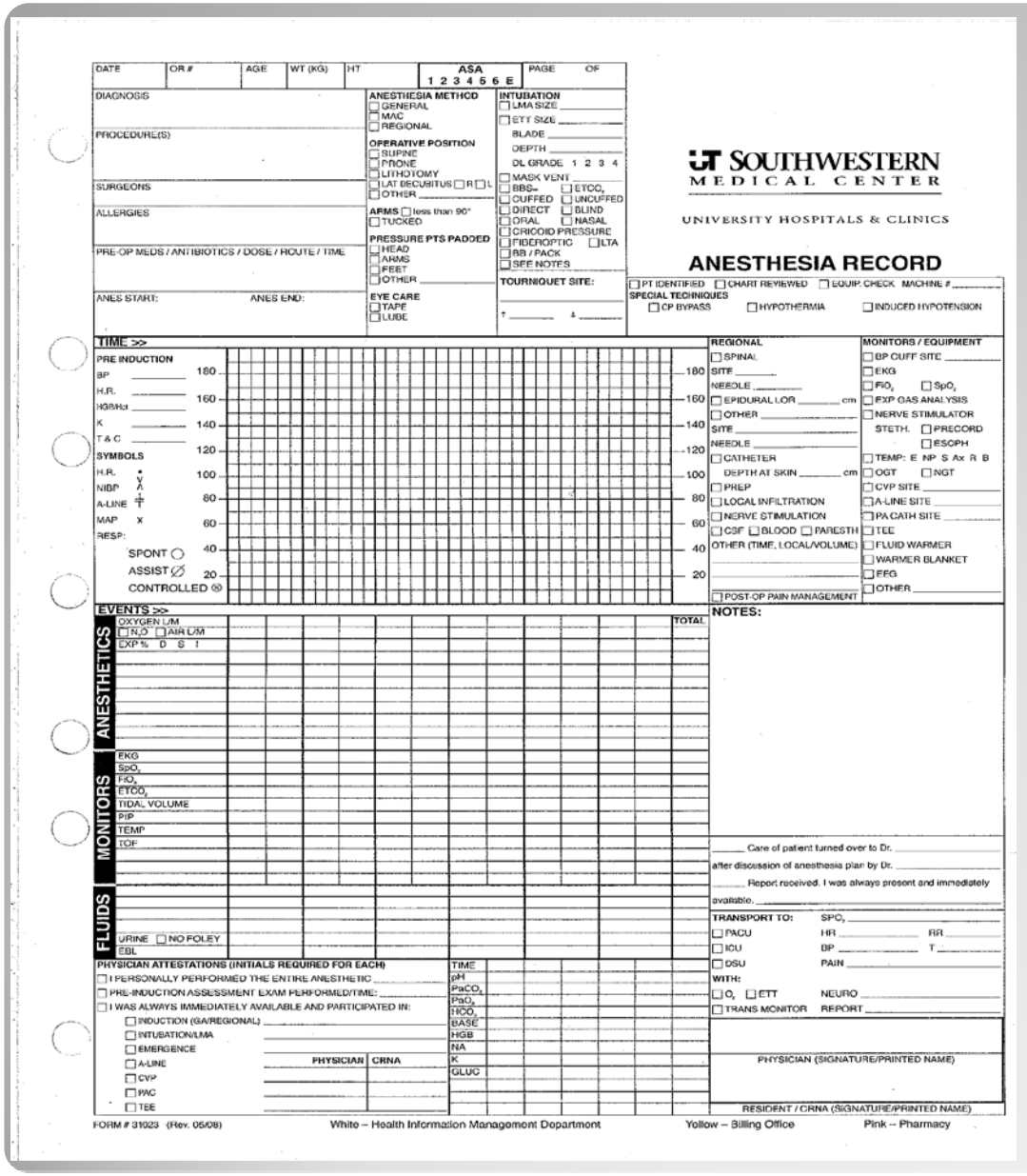
- Reconcile the Medical Records with OR log
- Check the documentation for the seven steps of medical direction
- Return incomplete records to physician
- Perform quarterly Audits
- Provide Education for the Physician
- Work with the Institutional Compliance Office

Potential Documentation Compliance Issues

- Start time
- Stop time
- Discontinuous time
- Invasive monitors
- Medical necessity
- Medical direction
- Medical Supervision
- Concurrence
- Key portions
- Monitoring course of anesthesia
- Transfer of care

Documenting the Anesthesia Record

If it isn’t documented it did not happen.



DATE | OR # | AGE | WT (KG) | HT | ASA 1 2 3 4 5 6 E | PAGE OF

DIAGNOSIS

PROCEDURE(S)

SURGEONS

ALLERGIES

PRE-OP MEDS / ANTIBIOTICS / DOSE / ROUTE / TIME

ANES START: ANES END:

ANESTHESIA METHOD: ☐ GENERAL ☐ MAC ☐ REGIONAL

OPERATIVE POSITION: ☐ SUPINE ☐ PRONE ☐ LITHOTOMY ☐ LAT DECUBITUS ☐ R ☐ L ☐ OTHER

ARMS ☐ less than 90° ☐ TUCKED

PRESSURE PTS PADDED: ☐ HEAD ☐ ARMS ☐ FEET ☐ OTHER

EYE CARE: ☐ TAPE ☐ LUBE

INTUBATION: ☐ LMA SIZE ☐ ETT SIZE BLADE DEPTH DL GRADE 1 2 3 4 ☐ MASK VENT ☐ BBG ☐ $ETCO_2$ ☐ CUFFED ☐ UNCUFFED ☐ DIRECT ☐ BLIND ☐ ORAL ☐ NASAL ☐ CRICOID PRESSURE ☐ FIBEROPTIC ☐ LTA ☐ BB / PACK ☐ SEE NOTES

TOURNIQUET SITE:

UT SOUTHWESTERN MEDICAL CENTER

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ANESTHESIA RECORD

☐ PT IDENTIFIED ☐ CHART REVIEWED ☐ EQUIP. CHECK MACHINE # _____

SPECIAL TECHNIQUES: ☐ CP BYPASS ☐ HYPOTHERMIA ☐ INDUCED HYPOTENSION

TIME >>

PRE INDUCTION: BP _____ H.R. _____ HGB/Hct _____ K _____ T & C _____

SYMBOLS: H.R. • NIBP V A-LINE ╪ MAP X RESP: SPONT ◯ ASSIST ∅ CONTROLLED ⊗

180 160 140 120 100 80 60 40 20

REGIONAL: ☐ SPINAL SITE _____ NEEDLE _____ ☐ EPIDURAL LOR _____ cm ☐ OTHER _____ SITE _____ NEEDLE _____ ☐ CATHETER DEPTH AT SKIN _____ cm ☐ PREP ☐ LOCAL INFILTRATION ☐ NERVE STIMULATION ☐ CSF ☐ BLOOD ☐ PARESTH OTHER (TIME, LOCAL/VOLUME) ☐ POST-OP PAIN MANAGEMENT

MONITORS / EQUIPMENT: ☐ BP CUFF SITE ☐ EKG ☐ FiO_2 ☐ SpO_2 ☐ EXP GAS ANALYSIS ☐ NERVE STIMULATOR STETH. ☐ PRECORD ☐ ESOPH ☐ TEMP: E NP S Ax R B ☐ OGT ☐ NGT ☐ CVP SITE ☐ A-LINE SITE ☐ PA CATH SITE ☐ TEE ☐ FLUID WARMER ☐ WARMER BLANKET ☐ EEG ☐ OTHER

EVENTS >> TOTAL

ANESTHETICS: OXYGEN L/M ☐ N_2O ☐ AIR L/M EXP % D S T

MONITORS: EKG, SpO_2, FiO_2, $ETCO_2$, TIDAL VOLUME, PIP, TEMP, TOF

FLUIDS: URINE ☐ NO FOLEY EBL

NOTES:

_____ Care of patient turned over to Dr. _____ after discussion of anesthesia plan by Dr. _____

_____ Report received. I was always present and immediately available. _____

TRANSPORT TO: ☐ PACU ☐ ICU ☐ DSU WITH: ☐ O_2 ☐ ETT ☐ TRANS MONITOR

SPO_2 _____ HR _____ RR _____ BP _____ T _____ PAIN _____ NEURO _____ REPORT _____

PHYSICIAN ATTESTATIONS (INITIALS REQUIRED FOR EACH)

☐ I PERSONALLY PERFORMED THE ENTIRE ANESTHETIC _____

☐ PRE-INDUCTION ASSESSMENT EXAM PERFORMED/TIME: _____

☐ I WAS ALWAYS IMMEDIATELY AVAILABLE AND PARTICIPATED IN:

☐ INDUCTION (GA/REGIONAL) _____ ☐ INTUBATION/LMA _____ ☐ EMERGENCE _____ ☐ A-LINE _____ ☐ CVP _____ ☐ PAC _____ ☐ TEE _____

PHYSICIAN | CRNA

TIME, pH, $PaCO_2$, PaO_2, HCO_3, BASE, HGB, NA, K, GLUC

PHYSICIAN (SIGNATURE/PRINTED NAME)

RESIDENT / CRNA (SIGNATURE/PRINTED NAME)

FORM # 31023 (Rev. 05/08) White – Health Information Management Department Yellow – Billing Office Pink – Pharmacy

Anesthesia Record

We currently use paper records at University Hospitals.

Our practice at CMC implemented electronic intra-operative anesthesia record in EPIC this past October.

Documenting the Anesthesia Record

- **Patient Name**
- **Place of Service**, inpatient, outpatient etc..
- **Date of Service**, date anesthesia was initiated
- **Name of Surgeon**
- **Anesthesia Start and Stop time**
- **Type of Anesthesia**, general, MAC, spinal, epidural etc…

Anesthesia Time

- Starts when the anesthesiologist begins to prepare the patient for anesthesia.
- Ends when the patient’s care is turned over to another type of provider for post surgical care.
- Anesthesia time should not be rounded.
- Always use the same time piece when determining start and stop time.

Documenting the Anesthesia Record (Cont'd).

- **Procedure**, surgical procedure performed
- **Diagnosis**, reason for the surgery, justification for the physical status modifier or MAC
- **Physical status modifier**, P3, P4, P5
- **Qualifying Circumstances**, extreme age, emergency conditions,controlled hypotension or hypothermia.

Documenting the Anesthesia Record (Cont'd)

- **Invasive Line Placements**, CVP, Arterial Line, PA Catheter
- **Date of Injury** (Workers Comp)
- **Medically Directing/Supervising Anesthesia Providers Statement,** to include the Anes. Plan Presence for induction, emergence, treatment of emergencies, availability and presence.

Documenting the Anesthesia Record (Cont'd).

- **Anesthesia MD/CRNA/Resident Signature (4).**
- **Pre Anesthesia Summary,** to include the pre anesthesia examination and evaluation and the Medically Directing/Supervising Anesthesia providers statement of participation and signature. (1)
- **Post Anesthesia Care,** statement indicating the status of patient and signature of Medically Directing/Supervising Anesthesia MD (7)

OB Anesthesia

OB EPIDURALS POST-ANESTHESIA TIME

If the faculty is only present for insertion of the labor epidural, then post anesthesia evaluation time should be the ending time of the insertion, when faculty deem the anesthetic successful and the patient to be comfortable.

If the case goes from LEA to an operative session (for example: C/S, BTL, forceps, D&C) the post-anesthesia time would be end of the operative session.

Different faculty may perform the follow-up after the epidural is removed by a resident, RRNA, CRNA and/or nurse. Faculty evaluations after the epidurals are removed ***must* be documented in the progress notes.**

NOTE:

For **OPERATIVE CASES**: The post-anesthesia evaluation date/time ***should not*** be earlier than the anesthesia end time documented on page one of the anesthesia epidural record and the operative record.

For **LABOR EPIDURALS**: The post-anesthesia evaluation date/time ***may*** be earlier than the anesthesia end time.

Documenting the Anesthesia Record (Cont'd).

- **Statement indicating time of change in the Anesthesia MD,CRNA or Resident,** for anesthesia group practices.

Operational Challenges to Documentation Completion

Anesthesia Coding

- We manually code from the following documentation sources: the intra-operative anesthesia records, surgeons' op reports, Pre and Post Anesthesia records, and discharge summaries (to confirm diagnosis & special circumstances)

- All of our coders are certified by the American Academy of Professional Coders (CPC certification)

Anesthesia Coding

- Selecting a Procedure Code
  - CPT vs. ASA code
  - Multiple procedures use code with highest base
  - Add on codes
  - If possible use operative report
- Selecting a Diagnosis Code
  - Choose to the highest specificity (fourth and/or fifth digit).
  - Diagnosis needed to support medical necessity for anesthesia as well as procedure.

Monitored Anesthesia Care (MAC)

- Should include: Pre operative visit, intra operative care and post operative management.
- During procedure, anesthesia care team is present and provides a variety of services:
  - Monitoring of vital signs, maintaining patient's airway and evaluation of vital functions.
  - Diagnosis and treatment of problems which may occur
  - Administration of sedatives, analgesics, etc… as necessary.
  - Other medical services as needed.

Monitored Anesthesia Care (MAC) (Cont'd)

- Patient remains able to protect the airway for the majority of the procedure.
- Medical Necessity (Medicare LMRP)
- Reimbursement should be same as general anesthesia.
- Additional Modifier may be required.

Modifiers – Anesthesia Care Team

- AA – Anesthesia services performed personally by anesthesiologist
- QY – Anesthesiologist medically directs one CRNA
- QK – Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals
- AD – Medical supervision by a physician: more than four concurrent anesthesia procedures.
- QX – CRNA service: with medical direction by a physician
- QZ – CRNA service: without medical direction by a physician

Commonly Used Modifiers (Cont'd)

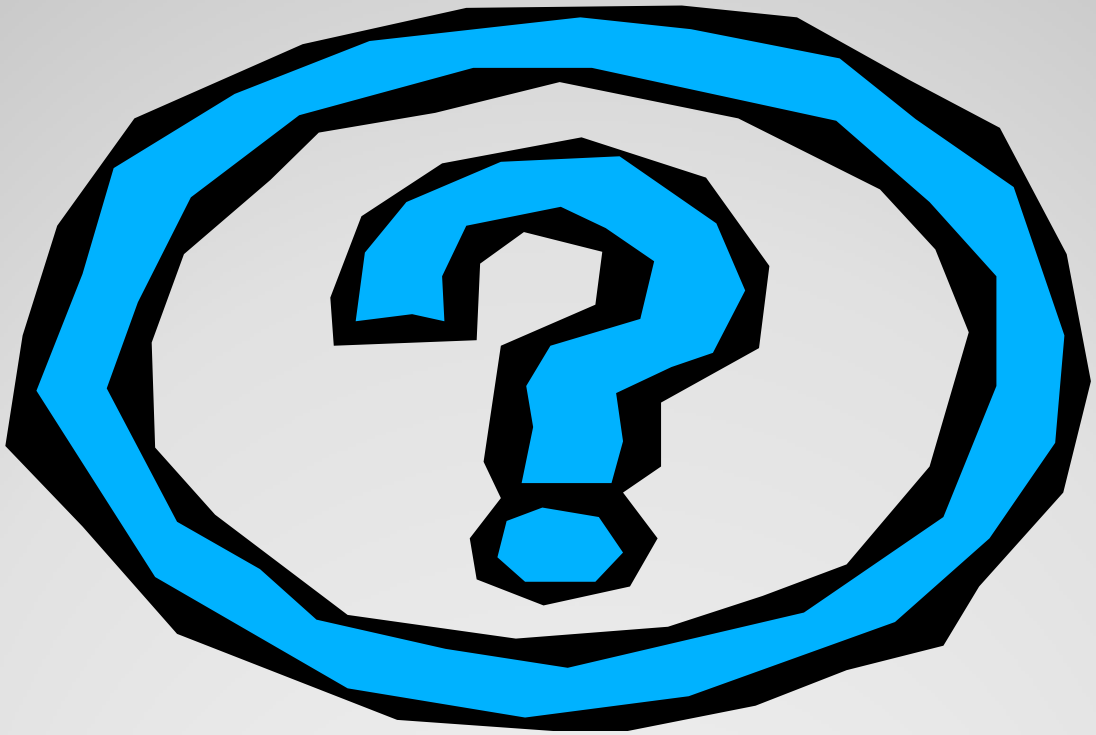
- Qualifying Circumstances (Add on codes)
  - 99100 – Anesthesia for patient of extreme age, under 1 year and over 70
  - 99116 – Anesthesia complicated by utilization of total body hypothermia
  - 99135 – Anesthesia complicated by utilization of controlled hypotension
  - 99140 – Anesthesia complicated by emergency conditions(specify).

Commonly Used Modifiers (Cont'd)

- -QS – Monitored anesthesia care service
- -G8 – Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedure
- -G9 – Monitored anesthesia care for patient who has history of severe cardio-pulmonary condition
- -GC This service has been performed in part by a resident under the direction of a teaching physician.

Resources

- AMA -CPT®
- ICD-9-CM
- ASA-Relative Value Guide
- ASA-Crosswalk
- Local Medicare and Medicaid Web Sites
- Anesthesia specialty publications
- Internet

Other Resources

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