Conquering Anesthesia Challenges

Present by
Judy A. Wilson, CPC, CPC-H, CPCO, CPC-P,CPC-I CANPC
AAPC NATIONAL LAS VEGAS CONFERENCE

Disclosures

- All material in this presentation is based on Medicare guidelines
- No other disclosures to report
Covered Topics

- Cancelled Anesthesia
- Failed Medical Direction
- Monitored Anesthesia Care (MAC)
- Time Issues
- Invasive Line Placement Rules
- TEE (Transesophageal Echocardiography) Rules
- Post-op Catheters/Blocks

Start/Stop Times

- Per Medicare Guidelines
- Anesthesia time begins when the anesthesiologist begins to prepare the patient for the anesthesia in the operating room or equivalent area, and ends when the anesthesiologist is no longer in actual attendance and the patient may be placed safely under post operative supervision.
What About Relief Time

- Relief must be documented – failure to do so could cause you compliance problems.
- An anesthesiologist can not relieve a CRNA that he/she is medically directing.
- Best Practice would be for CRNA to relieve CRNA and MD to relieve MD.
- When reporting the anesthesia time, bill with the anesthesiologist with the longest time on the case.

Rounding Up/Down

- Medicare wants start and stop time to be reported to the nearest minute.
- If a high number of cases are beginning or ending on the “5-minute mark” (i.e. 00:15, 14:35, etc.) you could become the proud winner of an audit.
Medicare’s Take on Time

- Data shows that on average, anesthesiologists usually spend no more than 7 minutes with the patient in the PACU before signing off on the case.
- If auditors find a larger percentage of PACU times to be more than 7 minutes, they may assume fraud unless you can prove otherwise.

Medicare’s Take on Time -Continued

- Vital signs are expected to be charted and match reported start and stop times.
- If Medicare does an audit, they will disallow any anesthesia time that exceeds charted vital signs, if more than one unit (i.e. 15 minutes).
Reporting Discontinuous Time

- CRNAs and anesthesiologists should only report the total anesthesia time on the CMS-1500 form as the sum of the continuous block of anesthesia time.
- Make sure that the record is documented so that an auditor can see the continuous and discontinuous periods. Make sure that the total anesthesia time sums to the blocks of continuous time.

Documenting of Discontinuous Time Is the Key

- Actual start and stop time needs to be documented in the appropriate areas
- Make sure you check the discontinuous time box
- In the remark section write legible notes
- Example:
  - 9:52-Anesthesia out time, waiting on surgeon
  - 10:02-Anesthesia in time
Post-OP Procedure and Invasive Line Placement and When/When Not To Bill Time

- Never bill time for placement of post-op block or invasive lines prior to the administration of the primary anesthetic for the surgery.
- These services are billed as a flat rate fee.
- After administration of the primary anesthetic **DO NOT** subtract time for the post-op block or invasive lines that the anesthesiologist place.

Post-OP Procedure and Invasive Line Placement & When/When Not To Bill Time Continued

- There will be no separate payment for multiple lumen placement. Exception would be if you do a CVP and a Swan-Ganz if they are two separate lines or two sticks. **Example on the next two slides.**
- Remember: To bill for the above, you must document both the line placements and the monitoring.
- Inserting of post-op block and invasive line placement can be done by the CRNA under direction of the anesthesiologist and is billable.
Invasive Lines Continued:
Documentation for Billing

- Patient identified. Consent obtained. Patient transferred to cardiac OR 3. Standard ASA monitors applied.
- Pre-oxygenation. Arterial lines placed per anesthesia record. Induction per anesthesia record. Endotracheal intubation per anesthesia record.
- Patient placed in Trendelenburg position for central venous catheter (CVC) placements and pulmonary artery catheter placement.
- Prep and technique per CDC protocol.
- Universal Protocol completed/time-out conducted prior to central line insertion
  - CVC #1: 4 lumen 8.5 French catheter: Placed in Right internal jugular vein. All ports aspirated and flushed. Sutured. Dressed after surgery completed.
  - Indications: Need/potential for vasoactive infusions; need for multiport access; need for secure, reliable intravenous access; and surgeon requests for postoperative use.
  - Pulmonary artery catheter/Pulmonary artery vent: Flushed. Balloon checked. Distal port flushed when placed in introducer. Floated easily.
  - Indications: Measurement of pulmonary artery pressures; pulmonary artery vent.

Invasive Line Continued:
Documentation for Billing Continued:

- Pulmonary artery catheter/pulmonary artery vent removed easily.
- Indications: Cardiac Output/Index; hemodynamic parameters (stroke volume, systemic vascular resistance, etc.); measurement of pulmonary artery pressures; and surgeon requests for postoperative use.
- Medicare PQRS (f/k/a/PQRI)
  - Cap_____________ YES
  - Mask_____________ YES
  - Sterile gown_______ YES
  - Sterile gloves_____ YES
  - Hand hygiene_____  YES
  - Antiseptic prep ____ YES
  - Large sterile drape__ YES
Transesophageal Echocardiography (TEE)

- TEEs can be done either for monitoring and/or diagnostic purposes.
- TEEs, when used to establish conditions such as myocardial ischemia or cardiac valve disorders, are diagnostic <strong>SHOULD</strong> be billed for.
- Must append a 59 to show that it is a separate and distinct procedural service. Will also need to append 26 for PC.
- The anesthesiologist must perform the placement, image acquisition, and interpretation (including a written report) to bill for these services. Codes 93312 and 93315 are <strong>NOT</strong> bundled into the anesthesia services.
- Code 93318 is bundled into the anesthesia services.
- TEEs require special training and certification.
- Note: Make sure you use a diagnosis for the TEE and not the surgical procedure.

**TEE BILLING SHEET EXAMPLE**

- [Patient Label Here]
- TEE Billing Form
- Date: __________________ Indication: ____________________________
- Surgeon: ____________________________ Echocardiographer: ________
- PROCEDURE CODE: (Check one; Congenital reimburses higher)
  - Basic Study (2-D imaging & report) 93312-26-59
  - Congenital Study (PFO, ASD, VSD, bicuspid aortic valve, etc) 93315-26-59

- ADD-ON CODES: (check any that apply)
  - PW/CW Doppler 93320-26
  - 3D without use of independent workstation 76376-26-59
  - Color Flow Doppler 93325-26
  - 3D with use of independent workstation 76377-26-59
  - Abnormal findings; radiological & other exams-intrathoracic organs 793.2

- ICD-9-CM CODES: (Check all that identify indication for TEE)
- MITRAL VALVE DISORDERS
  - Rheumatic MS 394.0
  - Rheumatic MR 394.1
  - Rheumatic MS with MR 394.2
  - Non-rheumatic MR or Insuff 424.0
TEE BILLING SHEET EXAMPLE

- AORTIC VALVE DISORDERS
  - [] DISORDERS AI, AR, AS 424.1

- COMBINED MITRAL & AORTIC VALVE DISEASE
  - [] MS with AS 396.0
  - [] MS with AI 396.1
  - [] MR with AS 396.2
  - [] MR with AI 396.3
  - [] MS and/or MR with AS and/or AI 396.8

- TRICUSPID VALVE
  - [] Rheumatic diseases of tricuspid valve 397.0
  - [] Non-rheumatic tricuspid valve disorder 424.2

- PULMONARY VALVE/CIRCULATION DISORDERS
  - [] Rheumatic diseases of pulmonary valve 397.1
  - [] Non-rheumatic pulmonary valve disorder 424.3
  - [] Acute cor pulmonale 415.0
  - [] Chronic pulmonary embolism 416.2
  - [] Arteriovenous fistula of pulmonary vessels 417.0

Time Spent On Placing Invasive Lines/Blocks

- Is time spent on placing invasive line or epidural catheters included in the anesthesia time?

- IT DEPENDS…
Time Spent on Placing Invasive Lines/Blocks Continued

- Placement of blocks post surgery and before anesthesia induction, or after anesthesia emergence, should *not* be included in the anesthesia time regardless of the sedation and monitoring that is provided to the patient during the block placement.

Time Spent on Placing Invasive Lines/Blocks Continued

- Blocks that occur after induction and prior to emergence are not deducted from the reported anesthesia time.
- If sedation is given for the sole purpose of placement of the block, it should not be included in reported anesthesia time.
Placement of Invasive Lines

- Arterial, central lines, etc. and/or regional blocks, epidurals, etc. are coded and billed AS SEPARATE PROCEDURES and ARE NOT included in reported anesthesia time.
- This means DO NOT record the anesthesia time as beginning prior to or during the placement of an invasive line or pain block.

Placement of Invasive Lines Continued

- REMEMBER: Only after the primary anesthetic is administered may you report and concurrently bill with the placement of regional blocks and/or for invasive lines.
How To Report Pain Procedures with Anesthesia

- Pain management service (64400-64530) with an operative anesthesia service: How would you report?
- According to the article in the 2/1997 issues of the CPT® Assistant, “Addition procedural services provided in conjunction with basic anesthesia administration are separately reportable and coded according to standard CPT section (e.g. Surgery or Medicine section; in which they are listed.”
- DO NOT CODE PROCEDURAL SERVICES WITH ANESTHESIA CODING GUIDELINES.

How To Report Pain Procedures with Anesthesia Continued

- What about time spent on placing nerve blocks for post op pain, spinal, arterial lines, etc. Should they be deducted from the start and stop time for anesthesia?
- Would the time spent on placing be deducted from the anesthesia time?
- Is there a difference between the arterial line being placed prior to placing the patient under anesthesia or after, with regard to discounting this placement time?
For Anyone Here Just for the CEUS!

- **CEU CODE:**
- **ENJOY**
- **MORE TO COME!**

**Placement of Lines**

- Anesthesia: According to the CPT® guidelines, the placement of lines such as the arterial, central venous lines, and Swan-Ganz catheter are separately reportable from the anesthesia services. Placement of these lines have no time associated with them because they are for monitoring purposes.
Placement of Lines Continued

- If Nerve blocks and epidurals placed for the purpose of post op pain control and NOT part of the anesthesia for the surgery being preformed are also separately reportable. When these services are done prior to the start of anesthesia time, you DO NOT add to the anesthesia time as these services are separate and distinct from the anesthesia services. It is not necessary to deduct time if these are done after induction of anesthesia time.

Time Spent on Post Anesthesia Care

- What time can be reported when an anesthesiologist or CRNA has to remain with a patient after emergence due to non-availability of nurse and/or a PACU bed, which can sometimes be up to as much 60 minutes or more?
- Some Medicare carriers have answered this question. (Colorado, Arkansas for a few) by stating that anesthesia time ends when the patient may be safely placed under post op care. The anesthesiologist may be permitted to report as much as one additional time unit (15 minutes) if he/she is present with the patient in the OR suite while patient is awaiting transfer.
Patient on Heart Pump, Anesthesiologist Leaves O.R. What Is Billable Time?

- Some anesthesiologists leave the OR when a patient is on pump. Is this billable time, even if the patient is on the heart pump?
- CMS and ASA clearly state that billable anesthesia time is continuous time with the patient. From a billing standpoint it is NOT APPROPRIATE to bill this time when the anesthesiologist is not present with the patient. The anesthesiologist should deduct any time away from the patient and report it as discontinuous time. If this is not done, anesthesiologists could be charged with a false claim.

More Than One Anesthesiologist Involved in One Patient’s Care

- In some unusual circumstances it may be medically necessary for two anesthesiologists to be involved in the care of a patient. Each physician would report his/her time using the correct modifiers (AA for physician or QZ if anesthesiologist and a CRNA). Documentation must be submitted by each provider to support payment of the full fee for each physician.
More Than One Anesthesiologist Involved in One Patient’s Care Continued

- When it is necessary to have two anesthesiologists or one anesthesiologist and one CRNA (not medically directed by an anesthesiologist), which is highly unusual, each **should report his/her services and send with a special report** that lets the carrier know why this was medically necessary.

Anesthesia Cases that Are Cancelled

- Billing for cancelled cases will depend on whether the case was cancelled before or after induction.

- Physician documentation should clearly state the time of cancellation and explanation.
Anesthesia Cases that Are Cancelled Continued

- **Before Induction:** Bill with the correct E/M code and give reason the case was cancelled, e.g. “case cancelled due to equipment failure,” etc.

- **After Induction:** Physician should bill with the correct CPT® code with modifier 53, 73, or 74, plus time. As you are aware, many carriers do not accept these modifiers. You can bill these cases with the correct anesthesia code with the full base units for the procedure that was to be done, plus total time that is documented on the anesthesia record. Reason for the cancellation should also be stated.

Monitored Anesthesia Care (MAC)

- **What is MAC?**
- It is continuous intraoperative monitoring of the patient’s vital signs in the event that general anesthesia is needed, or of any development of any adverse reaction to the surgical procedure. MAC requires anesthesia care. Anesthesiologists would be responsible for administration of any needed medications.

- **REMEMBER: IF THE PATIENT LOSES CONSCIOUSNESS, IT BECOMES GENERAL ANESTHESIA.**
Monitored Anesthesia Care (MAC) - Continued

- Medical Necessity is the key to billing MAC.
- Medicare as well as most other carriers reimburse MAC based on Medical necessity.
- Documentation is a must to support diagnoses to ensure reimbursement and compliance with LCD (LCDs will differ from carrier to carrier). Must keep up with LCD because they change rapidly.

Medical Direction

Steps of Medical Direction
- 1. Must perform the pre-anesthesia examination, along with evaluation.
- 2. Do the anesthesia plan.
- 3. Personally take part in the most demanding procedures of the anesthesia (must include the induction and emergence).
- 4. Any procedure in the anesthesia plan must be performed by a qualified anesthetist.
- 5. Must monitor anesthesia at intervals.
- 6. Must be physically present and available for immediate diagnosis and treatment of emergencies.
- 7. Must provide the post anesthesia care as indicated
What Services Are Allowed During Medical Direction

- You can address a medical emergency of short duration in the immediate area.
- You can administer an epidural to ease labor pain.
- You can perform periodic, but not continuous, monitoring for OB patients.
- You can receive a patient entering the operating room for the next surgery.
- You can check and discharge patients from the recovery room.
- You can coordinate scheduling matters.

What Is Considered an Emergency?

- **EMERGENCY** is defined when a delay in treatment of the patient would lead to a significant increase in the threat to life.
- Do you Agree? Medicare defines emergency for purpose of medical direction requirements to be the beginning delivery of anesthetic agents and ending when the patient is turned over to the staff/recovery room or other qualified staff.
Short Duration: What is Considered a Short Duration?

- You can address an emergency of **SHORT DURATION** in the immediate area. Is the duration considered short if it is one minute, one unit, or one hour?
- Medicare does not clearly define **short duration**.
- You must consider for yourself what constitutes a short duration. Remember to ask yourself if six of your peers would consider a short duration the same as you would.

What Is Immediately Available?
What Is Immediate Area?

- There are no concrete answers to these questions.
- CMS gives guidance on this but not a clear cut answer as to what is being immediately available and what is considered an immediate area.
- Remember: Immediate area does not mean three floors up or out of the building.
- Be consistent with your policy on these area and follow your Medicare provider’s guidelines.
Medical Direction Continued

- Anesthesiologists in a group may share the requirements for medical direction with anyone in that group practice, as long as all the conditions for medical direction are met and they document which services each performed.

How to Report Failed Medical Direction

- Method of reporting broken medical direction is different from state to state Medicare carriers.
- Example: State of Tennessee Medicare provider requires you to use the modifier QZ to report. The state of Missouri requires the use of modifier AD.
- Know what your carrier requires and keep up on the changes that are made to LCDs to keep you in compliance with your billing practices.
MAC & REGIONAL CASES

- Does induction & Emergence apply to MAC and Regional cases?
- Medicare would expect the physician to document in the record that he has been monitoring the patient and was available during the procedure, but would not expect to see any type of documentation of induction or emergence because these terms have no meaning for MAC or regional cases.

Recommendations to Keep Your Practice Compliant with Anesthesia Billing.

- Request clarification in writing from your Medicare Contractor when there is no written policy for your region, and maintain a file for all clarification you receive.
- Never assume that one Medicare Carrier’s policies are the same as another Medicare Carrier.
- Make sure your billers are informed of all rules that apply to your state for processing of your claims.
- DOCUMENT, DOCUMENT, DOCUMENT, AND MAKE IT LEGIBLE.
THANK YOU FOR ATTENDING!

- judy@anes.hrcoxmail.com
- QUESTION?
- CEU CODE