Anesthesia Coding and Compliance

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Introduction

The target for this training is to provide you with a basic understanding of anesthesia coding and compliance in regards to the following topics:

- Documentation
- Time
- Coding
- Additional billable services
- Medical Necessity
- Mode of Anesthesia
- PQRS
Documentation

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Documentation

- If it is not documented, it did **NOT** happen.
- Documentation is key and leads to:
  - Accurate Coding
  - Appropriate use of modifiers
  - Billing compliance
  - Maximized reimbursement

Can we read your handwriting?
The Centers for Medicare and Medicaid Services (CMS) has began to deny claims if the provider’s signature is illegible.

It is recommended that if your signature is illegible you print your name next to your signature.
Documentation, cont.

- The anesthesia record must provide the details needed to generate a claim.
  - **Who** (Patient, MD, CRNA)
  - **What** (Procedure Description, lines placed, P-status, etc.)
  - **When** (Date, start/stop times, relief times, etc.)
  - **Where** (facility name/OR #)
  - **Why** (diagnosis)
Time
When Does Anesthesia Time Start?

The Anesthesia Answer book defines anesthesia time as “the continuous actual presence of the anesthesiologist or CRNA; [anesthesia time] begins when the physician or anesthetist starts preparing the patient for the anesthesia procedure in the operating room or its ‘equivalent area’.”
Anesthesia Start Time

- Time is counted from the moment the practitioner -- having completed the preoperative evaluation – starts an intravenous line, places monitors, administers pre-anesthesia sedation or otherwise physically begins to prepare the patient for anesthesia.
Billable Pre-OR Start Time

- Administering sedation
- Regional block used as mode of anesthesia

- For these:
  - Need a start and end time

Example
IV start/pre-op meds; 0700-0705
in OR 0706

Incorrect Example
IV start/pre-op meds; 0700
in OR 0706
Discontinuous Time for Lines & Blocks

2014 Relative Value Guide (pg. 58)

- Time for a post surgical block that occurs after induction and prior to emergence does not need to be deducted from reported anesthesia time.
When Does Anesthesia Time End?

The Anesthesia Answer book defines anesthesia end time as “when the anesthesia practitioner is no longer in personal attendance, i.e. when the patient may be safely placed under post-operative supervision.”
Stop Time

- Document the time you transfer the care to the PACU staff

- Document the following 2 things:
  - Vitals until you exit the OR
  - Final patient status at care transfer time
Stop Time Discussion

- Extended time after emergence from the primary anesthetic should be supported on the anesthesia record by:
  - Documentation of events that prolonged your attendance.
Anesthesia Time

- Enter exact times only—DO NOT round times up or down or use intervals of 5.

- The end time and start time between abutting cases must be documented at least one (1) minute apart.

- Check your work
  - Double check the dates of service and times on each case.
Anesthesia Time, cont.

- Relief – When one practitioner relieves another during a case, the record must clearly reflect the relief times (start and stop) and the provider rendering the relief

- Use military time only

- Utilize one consistent time piece
  - Personal watch
  - Atomic clocks that are synced
Anesthesia Time, cont.

- Time spent performing the pre-anesthesia assessment or post-anesthetic evaluation (after release to PACU) is **NOT** billable time and should not be calculated in with your reportable anesthesia time.
Second Anesthesia Provider

- Per the ASA, “When it is necessary to have a second attending anesthesia provider assist with the provision of anesthesia, these extraordinary circumstances should be substantiated by special report.”

- Supporting Documentation
  - Medical Necessity for 2nd anesthesia provider
  - Detailed documentation of the anesthesia services provided—what roles as the second anesthesia provider did you take in provision of care to the patient
  - Medical record document must support the start and stop time of the 2nd provider
Canceled Anesthesia Case

- Canceled prior to induction – surgery not rescheduled within 48 hours
  - Bill appropriate E/M code per documentation in the pre-anesthetic evaluation
    - 99231 – 99233 (subsequent hospital visit)
    - 99201 – 99205 (new patient office/outpatient)
    - 99212 – 99215 (subsequent patient office/outpatient)

- Canceled after induction
  - Bill applicable ASA code with base and time
  - Can add modifier 53 for discontinued procedure
Coding Descriptions

- Procedure/Diagnosis coding provides an accurate representation of the health care services through complete and precise documentation.

- Detailed documentation should include definition of severity, comorbidities, complications, manifestations, causes and any other characteristics that classify the patient’s condition.
Coding for Accurate Reimbursement

- Surgical vs. Diagnostic
- Positioning - prone, RLD, LLD
Coding for Reimbursement, cont.

- Integumentary Systems - anatomical site
- Axillary region (node biopsy/lumpectomies)
Coding for Reimbursement, cont.

- One lung ventilations (OLV)
- Cardiac Bypass- on/off pump
Coding for Reimbursement, cont.

- Abdomen- upper/lower
- Hernias- specify with or without obstruction/strangulation
- Stones- specify kidney, upper ureter, ureter or bladder
Coding for Reimbursement, cont.

- Limbs- distal/proximal
- Replacement vs. revision joint replacement
Coding for Reimbursement, cont.

- Instrumentation/multiple levels on spinal surgeries
Key Revision in the 2013 Relative Value Guide (RVG)

- Revised RVG Coding Comment

- **00670**  
  Anesthesia for extensive spine and spinal cord procedures (eg, spinal instrumentation or vascular procedures)

  - **RVG COMMENT:** Code 00670 is appropriate only if the surgical procedure **includes segmental or non-segmental instrumentation** as defined in CPT or if the procedure **includes multiple vertebral segments** (minimum three vertebral bodies with the two associated interspaces.)
CRNA Modifiers

- **QY- Medical Direction**
  - Medical direction of one CRNA by a physician

- **QX - CRNA medically directed**
  - with medical direction of 2-4 CRNAs by a physician

- **AD - Medical Supervision by a physician**
  - more than 4 concurrent anesthesia procedures

- **QZ- CRNA Service**
  - without medical direction by a physician
Physical Status Modifiers

- **P1** - Normal, healthy patient
- **P2** - Patient with mild systemic disease
- **P3** - Patient with severe systemic disease (includes morbid obesity) - ONE BASE UNIT
- **P4** - Patient with severe systemic disease that is a constant threat to life. - TWO BASE UNITS
- **P5** - Moribund patient who is not expected to survive without surgery. - THREE BASE UNITS
- **P6** - Declared brain-dead patient whose organs are removed for donor purposes
Qualifying Circumstances Modifiers

- **99100** - Extreme age (Under 1 or 70 yrs or >) – 1 Base Unit
- **99116** - Hypothermia (20'C or below) – 5 Base Units
  - Should include documentation of “surgeon's request"
- **99135** - Hypotension – 5 Base Units
  - Controlled or induced hypotension is billable only when done in a deliberate and formal manner and “per surgeon’s request”
- **99140** - Emergency – 2 Base Units
  - “[A]n emergency is defined as existing when delay in treatment of the patient would lead to significant increase in the threat to life or body part.”
Invasive Monitoring Lines

- A-line, CVP, and Swan-Ganz catheter
  - Documentation in anesthesia record should support performance of the procedure (who, needle/cath size, and location)
    - Ex: 20g rt radial a-line placed atraumatically
- Bill under provider who performed the service
- OK to bill both CVP and Swan Ganz if two separately documented lines (two insertion sites)
Ultrasound Guidance

- **76942** - Ultrasonic guidance for **needle placement** (e.g. biopsy, aspiration, injection, localization device), imaging supervision and interpretation.

  **Requirements:**
  - Permanent recorded images of the site to be localized
  - Documented description of the localization process

- **76937** - Ultrasound guidance for vascular access, has specific requirements that must be met.

  **Requirements:**
  - Ultrasound evaluation of potential access sites
  - Documentation of selected vessel patency
  - Concurrent real-time ultrasound visualization of vascular needle entry
  - Permanent recording and reporting
Post-op Pain Management

- Includes epidurals, spinals and blocks
- Can be billed on same day as surgery w/ -59 modifier if **NOT** the primary anesthetic technique
  - Was the anesthesia for the surgical procedure dependent upon the efficacy of the regional block?
- Requires documented transfer/request of care for post-op pain management from surgeon
Post-op Pain Management

- Do not bill separately for subarachnoid injection or epidural catheter placement if “combined spinal epidural” (CSE) technique utilized (one procedure).

- A procedure note should be included in the medical record to identify the location, technique, drugs, complications, and the performing provider, along with documentation to support the procedure was for post-op pain management at surgeon’s request.
Post-op Pain Management

- Medicare administrative contractors (MAC) have recently made changes to their post op pain management LCD’s.

- **Noridian:**
  
  “Reimbursement for the control or management of acute pain in the immediate postoperative period is generally packaged into the payment for the surgical procedure. However, if a need for transfer of pain management is documented and ordered by the surgeon and the accepting provider documents the need for and acceptance of transfer of care, separate reimbursement may be made for the service.”

- **WPS:**
  
  “Postoperative pain management services are generally provided by the surgeon who is reimbursed under a global payment policy related to the procedure and shall not be reported by the anesthesia practitioner unless separate, medically necessary services are required that cannot be rendered by the surgeon. The surgeon is responsible to document in the medical record the reason care is being referred to the anesthesia practitioner.”
Post-op Pain Management

- **01996** – daily hospital management of epidural/subarachnoid continuous drug administration
  - Billed beginning the day after catheter placement
  - Not appropriate for follow-up of peripheral nerve catheters, Duramorph rounding (no existing catheter) or IV PCA management

- **99231-99233** – Use if follow-up care is required (medically necessary) for a single injection, continuous infusion by catheter nerve block or duramorph rounding
  - Typically, a low level subsequent hospital visit (99231) is most often supported
  - Not billable if provided the same day as block/catheter insertion
  - Duramorph rounding is only billable if the spinal was placed for post-op pain and the surgery was general anesthesia
Post-Operative Pain Rounding
E&M CPT Code 99231

- Documentation should include that the majority of the visit was to assess if there were any side effects from the injection and the drug that was administered.

- There must also be documentation to support the clinical medical necessity of rounding on the patient because of the nature of the drug and the duration that the drug stays in the body.
Post-Operative Pain Rounding
E&M CPT Code 99231

- The CPT manual also dictates specific requirements for billing the 99231 E&M service. The CPT manual specifies the following requirements:

  - **99231 Subsequent hospital care**, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components.
    - A problem focused interval history;
    - A problem focused examination;
    - Medical decision making that is straightforward or of low complexity.
Mode of Anesthesia

- General
- Monitored Anesthesia Care (MAC)
- Local/Regional block
General Anesthesia

- General Anesthesia: a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory support is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

- Per the 2014 Relative Value Guide book (page 45)
  - If the patient loses consciousness and the ability to respond purposefully, the anesthesia care is a general anesthetic, irrespective of whether airway instrumentation is required.
Monitored Anesthesia Care (MAC)

- Monitored Anesthesia Care (MAC): anesthesia care that includes the monitoring of the patient by a practitioner who is qualified to administer anesthesia as defined by the regulations at §482.52(a). Indications for MAC depend on the nature of the procedure, the patient’s clinical condition, and/or the potential need to convert to a general or regional anesthetic.

- Per the ASA Relative Value Guide – Position on MAC (page 45)
  - Monitored anesthesia care includes all aspects of anesthesia care. Monitored anesthesia care may include varying levels of sedation, analgesia, and anxiolysis as necessary. The provider of MAC must be prepared and qualified to convert to general anesthesia when necessary.

- Medicare Administrative Contractors have very specific MAC policies. It is imperative that you understand the requirements for reimbursement of MAC procedures from your local Medicare Contractor.
Monitored Anesthesia Care Modifiers

QS - Monitored anesthesia care service

G8 - Monitored anesthesia care (MAC)
   deep complex complicated, or markedly invasive surgical procedures

G9 - Monitored anesthesia care (MAC)
   patient w/ history of severe cardio- pulmonary condition
Regional Anesthesia

- Regional Anesthesia: the delivery of anesthetic medication at a specific level of the spinal cord and/or to peripheral nerves, including epidurals and spinals and other central neuraxial nerve blocks, is used when loss of consciousness is not desired but sufficient analgesia and loss of voluntary and involuntary movement is required.
Medical Necessity

- Defined as those services that are reasonable and necessary for the diagnosis or treatment of an illness or injury, or to improve the functioning of a malformed body member and are not excluded under a patient’s insurance plan.

- The necessity of the procedure must be carefully documented and must meet the standards of good medical practice in the local area.
Medical Necessity

- You must demonstrate that the services are **not** mainly for the convenience of the **patient** or **provider**. Pay particular attention to carefully document medical necessity for:
  - MAC
    - GI procedures
    - Skin procedures
    - Cath Lab procedures
    - Spinal and minor joint injections
  - Post-op pain
  - Invasive Lines
Physician Quality Reporting Systems (PQRS)
2014 PQRS Program

In the 2014 PQRS program there are 4 measures for anesthesia providers to report. They are as follows:

- **Measure #30**: Perioperative Care: timing of Prophylactic Antibiotics - Administering Physician
- **Measure #44**: Perioperative Beta-Blocker in patients with Isolated CABG surgery
- **Measure #76**: Prevention of Catheter-Related Bloodstream Infections (CRBSI): Central Venous Catheter (CVC) Insertion Protocol
- **Measure #193**: Perioperative Temperature Management
Incentive Amounts

- January 1- December 31, 2014 = 0.5% of estimated total allowed charges for covered Medicare Part B Physician Fee Schedule services.

- Providers must report at least 50% of applicable cases, for at least 3 measures, to be eligible for incentive payments and to avoid the 2016 penalty.

- Incentive payments earned will be paid to the TIN under which the incentive-earning professional submitted PQRS claims.
CMS Penalty for Non-Participation or Unsuccessful Reporting

- CMS finalized in its 2012 Medicare Physician Fee Schedule that 2016 program penalties will be based on 2014 performance.

Therefore, those eligible professionals who elect not to participate or are found unsuccessful during the 2014 program year, will receive a 2 percent penalty in 2016.
Measure #30

Perioperative Care: Timing of Prophylactic Antibiotics-Administering Physician.

CMS Description:

Percentage of surgical patients aged 18 years and older who receive an anesthetic when undergoing procedures with the indications for prophylactic parenteral antibiotics for whom administration of the prophylactic parenteral antibiotic ordered has been initiated within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required)
Measure #30, cont.

2014 Codes:

- **4047F-8P**: Antibiotic Not Ordered
- **4048F**: Administered Within Specified Timeframe
- **4048F-1P**: Antibiotic Not Administered for Medical Reasons
- **4048F-8P**: Antibiotic Ordered but Not Initiated Within One Hour, Reason not Specified
Measure #44
Perioperative Beta-Blocker in patients with Isolated CABG surgery

CMS Description:
Percentage of isolated Coronary Artery Bypass Graft (CABG) surgeries for patients aged 18 years and older who received a beta-blocker within 24 hours prior to surgical incision.
Measure #44, cont.

2014 Codes:

- **4115F:** Beta blocker administered within 24 hours prior to surgical incision

- **4115F-1P:** Beta blocker not administered within 24 hours prior to surgical incision, for medical reasons

- **4115F-8P:** Beta blocker not received, reason not specified
Measure #76

CMS Description:
Percentage of patients, regardless of age, who undergo CVC insertion for whom CVC was inserted with all elements of maximal sterile barrier technique [cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis (or acceptable alternative antiseptics per current guideline)] followed
Measure #76, cont.

2014 Codes:

- **6030F**: All Elements of Maximal Sterile Barrier Technique Followed

- **6030F-1P**: All Elements of Maximal Sterile Barrier Technique **Not** Followed for Medical Reasons

- **6030F-8P**: All Elements of Maximal Sterile Barrier Technique **Not** Followed, Reason not Specified
Measure #193
Perioperative Temperature Management

Percentage of patients, regardless of age, undergoing surgical or therapeutic procedures under general or neuraxial anesthesia of 60 minutes duration or longer, except patients undergoing cardiopulmonary bypass, for whom either active warming was used intraoperatively for the purpose of maintaining normothermia, OR at least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) was recorded within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time

Definition: For purposes of this measure, “active warming” is limited to over-the-body active warming (e.g., forced air, warm-water garments, and resistive heating blankets).
Measure #193, cont.

Active Warming Used Intraoperatively OR At Least One Body Temperature Equal to or Greater than 36 Degrees Centigrade Recorded Within Designated Timeframe

(Two CPT II codes [4250F & 4255F] are required on the claim form to submit this numerator option)

- **4250F**: Active warming used intraoperatively for the purpose of maintaining normothermia, OR at least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) recorded within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time.

AND

- **4255F**: Duration of general or neuraxial anesthesia 60 minutes or longer, as documented in the anesthesia record
Measure #193, cont.

Active Warming Not Performed OR at Least One Body Temperature Equal to or Greater than 36 Degrees Centigrade not Achieved Within Designated Timeframe for one of the following Medical Reasons:

(Two CPT II codes [4250F-1P & 4255F] are required on the claim form to submit this numerator option)

- **4250F-1P**: Intentional hypothermia OR active warming not indicated due to anesthetic technique: peripheral nerve block without general anesthesia, OR monitored anesthesia care

AND

- **4255F**: Duration of general or neuraxial anesthesia 60 minutes or longer, as documented in the anesthesia record
Measure #193, cont.

If patient does not meet denominator inclusion because anesthesia time as indicated on the anesthesia record is less than 60 minutes duration:

(One CPT II code [4256F] is required on the claim form to submit this numerator option)

- **4256F**: Duration of general or neuraxial anesthesia less than 60 minutes, as documented in the anesthesia record. This refers to total anesthesia time, from anesthesia start time to stop time.
Measure #193, cont.

Active Warming Not Performed OR at Least One Body Temperature Equal to or Greater than 36 Degrees Centigrade Not Achieved Within Designated Timeframe, Reason Not Specified

(Two CPT II codes [4250F-8P & 4255F] are required on the claim form to submit this numerator option)

- **4250F-8P**: Active warming not performed OR at least one body temperature equal to or greater than 36 degrees Centigrade Not Achieved within designated timeframe, reason not otherwise specified

AND

- **4255F**: Duration of general or neuraxial anesthesia 60 minutes or longer, as documented in the anesthesia record
PQRS & Reporting the Data

- There is one reporting period for 2014

- The burden of proof falls to the provider to accurately report the services given.

- Providers need to be aware that you cannot go back to report PQRS information once the claim has been sent.
Questions?

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