Medical Compliance Services
Office of Billing Compliance
Coding, Billing &
Documentation
2017

Department of Anesthesiology
## Top Billed Non-E/M Codes

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Procedure Code</th>
<th>Procedure Quantity</th>
<th>% of Total</th>
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</thead>
<tbody>
<tr>
<td>ANESTH, LENS SURGERY [00142]</td>
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<tr>
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<tr>
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<tr>
<td>PR ANESTH, NECK ORG PROC; NOS, AGE 1 YR/OLD [00320]</td>
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<tr>
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<tr>
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### Top Billed E/M Codes

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Procedure Code</th>
<th>Procedure Quantity</th>
<th>% of Total</th>
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<tbody>
<tr>
<td>PR CRITICAL CARE, E/M 30-74 MINUTES [99291]</td>
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<tr>
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<tr>
<td>PR OFFICE/OUTPT VISIT, EST, LEVL III [99213]</td>
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<tr>
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<td>99204</td>
<td>73</td>
<td>2.86%</td>
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Bell Curves
Departmental Data Compared to National Data

**Anesthesiology**

### New Office Visits

<table>
<thead>
<tr>
<th>E&amp;M Code</th>
<th>Count</th>
<th>Current Practice Dist. %</th>
<th>National Dist. %</th>
<th>Variance Practice vs. National</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>3</td>
<td>1.40%</td>
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<tr>
<td>99202</td>
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<td>6.10%</td>
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<tr>
<td>99203</td>
<td>81</td>
<td>37.67%</td>
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<tr>
<td>99205</td>
<td>45</td>
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<td><strong>Totals</strong></td>
<td><strong>215</strong></td>
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### Established Office Visits

<table>
<thead>
<tr>
<th>E&amp;M Code</th>
<th>Count</th>
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<th>National Dist. %</th>
<th>Variance Practice vs. National</th>
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</thead>
<tbody>
<tr>
<td>99211</td>
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<tr>
<td>99212</td>
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<td>21.93%</td>
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<td><strong>100.00%</strong></td>
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# Departmental Data Compared to National Data

## Initial Hospital Visits

<table>
<thead>
<tr>
<th>E&amp;M Code</th>
<th>Count</th>
<th>Current Practice Dist. %</th>
<th>National Dist. %</th>
<th>Variance Practice vs. National</th>
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<tbody>
<tr>
<td>99221</td>
<td>5</td>
<td>4.55%</td>
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<tr>
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<td>102</td>
<td>92.73%</td>
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<td>54.95%</td>
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<tr>
<td>99223</td>
<td>3</td>
<td>2.73%</td>
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<td>-27.63%</td>
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<td><strong>Totals</strong></td>
<td><strong>110</strong></td>
<td><strong>100.00%</strong></td>
<td><strong>100.00%</strong></td>
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## Subsequent Hospital Visits

<table>
<thead>
<tr>
<th>E&amp;M Code</th>
<th>Count</th>
<th>Current Practice Dist. %</th>
<th>National Dist. %</th>
<th>Variance Practice vs. National</th>
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</thead>
<tbody>
<tr>
<td>99231</td>
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<td>3.75%</td>
<td>44.70%</td>
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<td>73.45%</td>
<td>30.96%</td>
<td>42.48%</td>
</tr>
<tr>
<td>99233</td>
<td>158</td>
<td>22.80%</td>
<td>24.34%</td>
<td>-1.54%</td>
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<tr>
<td><strong>Totals</strong></td>
<td><strong>693</strong></td>
<td><strong>100.00%</strong></td>
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</tbody>
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2017 Code Changes
New Moderate Sedation Codes
(Deleted Previous CPT codes for moderate sedation, 99143-99150)

As a result of the 2017 Physician Fee Schedule, moderate sedation will be separately billed and paid starting in 2017 using new CPT® codes.

Moderate (also known as conscious) sedation is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain cardiovascular function or a patent airway, and spontaneous ventilation is adequate.

1. If you provide moderate (conscious) sedation in conjunction with a procedures you must now bill sedation separately.

2. Payment for moderate sedation is no longer included in the allowances for any codes. Failure to report these new moderate sedation code(s) will result in loss of payment for this service.

3. Documentation for moderate sedation services and time must be maintained in the patient record.
Moderate Sedation Services Provided by the Same Physician

- **99151**  Moderate sedation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the sedation supports, requiring the presence of an independent trained observer to assist in the monitoring of the patient’s level of consciousness and physiological status; initial 15 minutes of intra-service time, patient younger than five years of age
- **99152**  ; initial 15 minutes of intra-service time, patient age 5 years or older
- **+99153**  ; each additional 15 minutes of intra-service time (List separately in addition to code for primary service)

An independent trained observer is an individual who is qualified to monitor the patient during the procedure, who has no other duties (eg, assisting at surgery) during the procedure.
General Anesthesia
Anesthesia CoP Documentation Requirements

Anesthesia - Specific Documentation Recommendations:

- Pre-Anesthesia evaluation
  - CMS requirements include that a pre-anesthesia evaluation must be performed within 48 hours of the induction of anesthesia by an anesthesia practitioner.

- Intra – Operative Record
  - Attendance during procedure – Presence induction, emergence, key portions and any separate billed procedures (lines etc.)

- Post-Anesthesia Care Unit Evaluation
  - CMS requirements include that a post-anesthesia evaluation must be performed within 48 hours after the conclusion of anesthesia by an "individual qualified to administer anesthesia".
Pre-Anesthesia Evaluation: 48 Hours Prior

• If evaluation was performed >48 hours from service, then update must be documented.
  • Include a notation (handwritten or pre-printed) on the anesthesia record that the patient was evaluated immediately prior to induction with a signature by the attending anesthesiologist attesting to the statement.

Question: What is the minimum acceptable documentation for pre-anesthesia evaluation for procedures that are staged (multiple during the same month)? Can you perform only one pre-anesthesia eval for all procedures staged within the same month?
Intra-Operative Anesthesia Record

• The anesthesia record (time-based record of events) should indicate:
  • Patient’s vital signs including temperature, oxygenation, ventilation and circulation
  • Type of anesthesia administered (e.g., MAC, general, etc.)
  • Amount of all drugs and agents used including times given
  • Unusual events occurring during the anesthesia monitoring period
  • Total time
  • Provision of indicated post anesthesia care
Post - Anesthesia Record: Within 48 Hours

• As indicated:
  • Evaluation on admission and discharge from post anesthesia;
  • Time based record of vitals signs and level of consciousness;
  • Drugs provided to the patient including the dosage and time;
  • Any unusual post anesthesia events or complications;
  • Post anesthesia visits and follow-up;
  • Initiation of any pain management services such as patient controlled anesthesia.

An individual qualified to administer anesthesia must perform a post anesthesia evaluation.
§482.52 Condition of Participation: Anesthesia Services

The elements of an adequate post-anesthesia evaluation should be clearly documented and conform to current standards of anesthesia care, including:

- Respiratory function, including respiratory rate, airway patency, and oxygen saturation;
- Cardiovascular function, including pulse rate and blood pressure;
- Mental status;
- Temperature;
- Pain;
- Nausea and vomiting; and
- Postoperative hydration.
Changes of Personnel and Concurrency

- Changes in anesthesia personnel during the course of an anesthetic occurs for:
  - Attending anesthesiologist
  - Resident
  - Nurse anesthetist

- Clearly document
  - Name of person assuming care
  - Time care was transferred

- When calculating primary and secondary concurrency it is imperative that time is accurately recorded. It is necessary to record and compare both the primary physician and the relieving physician (2* concurrency) when determining personally performed and medical direction for billing and modifiers.
Time – ASA & CPT

Anesthesia time starts when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room or in an equivalent area and ends when the anesthesiologist is no longer in personal attendance; that is, when the patient may be safely placed under post-anesthesia supervision.
Billing Modifiers Affecting Payments

• **Modifiers Used By Anesthesiologists**
  - **AA:** Anesthesia services performed personally by anesthesiologist or an anesthesiologist working with 1 or 2 residents only
  - **AD:** Medical supervision by a physician (anesthesiologist); more than four concurrent anesthesia procedures or medical direction not met
  - **QK:** Medical direction of two, three or four concurrent anesthesia procedures
  - **QY:** Anesthesiologist medically directs one CRNA

• **Modifiers Used By CRNAs**
  - **QX:** CRNA service with medical direction by a physician
Physical Status Modifier: added to each reported anesthesia code to indicate the patient's condition at the time anesthesia was administered

P1  Normal, healthy patient.

P2  Patient with mild systemic disease; e.g. anemia, chronic asthma, chronic bronchitis, diabetes mellitus, essential hypertension, heart disease that only slightly limits physical activity, obesity.

P3  Patient with severe systemic disease; e.g. angina pectoris, chronic pulmonary disease that limits activity, history of prior myocardial infarction, heart disease that limits activity, poorly controlled essential hypertension, morbid obesity, diabetes mellitus, type I with vascular complications.

P4  Patient with severe systemic disease that is a constant threat to life; e.g. advanced pulmonary/renal/hepatic dysfunction, congestive heart failure, persistent angina pectoris, unstable/rest angina.

P5  Moribund patient who is not expected to survive without the operation.

P6  Declared brain-dead patient whose organs are being removed for donor purposes.
Medical Direction Criteria: The “7 Steps”

“Medical direction” occurs when an anesthesiologist works with two, three or four concurrent cases with CRNA’s and residents.

Seven required documentation criteria:
1. Performs a pre-anesthesia evaluation
2. Prescribes the anesthesia plan
3. Personally participates in the most demanding aspects of the anesthesia plan including, if applicable, induction and emergence
Medical Direction (cont.)

4. Ensures 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 administration at frequent intervals

6. Remains physically present and available for immediate diagnosis and treatment of emergencies

7. Provides indicated post-anesthesia care. This MUST be documented by the attending physician and is required for billing.

**Documentation/Attestation For the 7 Stepa Required By Anesthesiologist For Billing**
Medical Direction Things You CAN Do

• Emergency of short duration
• Epidural/caudal for labor patient
• Periodic monitoring of OB patient
• Receive patients for next surgery
• Check on/discharge from PACU
• Coordinate scheduling
• Short breaks to use the bathroom etc. or quick snack
Medical Direction Things You CAN Do

Question to CMS: Do you agree that the medically directing anesthesiologist may perform duties such as placement of lines and epidurals in the holding areas consistent with this policy?

Yes, we agree that such duties are reasonable, consistent with sound medical practice, and would not cause the medically directing anesthesiologist to be in violation of CMS's rules for medical direction. As long as the medically directing anesthesiologist "remains physically present and available for immediate diagnosis and treatment of emergencies". We would agree that the following procedures would be an illustrative but not exclusive list of allowed interventions:

- Placement of a Swanz-Ganz catheter, central line, or arterial line
- Placement of an epidural catheter for post-operative analgesia or in preparation for subsequent surgery (for a "to follow case")
- Placement of other peripheral nerve blocks prior to subsequent surgery, to include brachial plexus blocks, ankle blocks, femoral nerve blocks, etc.

The series of questions and answers were published in November 1999 by a Medicare carrier in response to 18 questions submitted by the Georgia Society of Anesthesiologists. The responses were the result of negotiations between those parties as well as the ASA and CMS (then HCFA).
Medical Direction Things You CAN’T Do

• Personally provide an anesthetic except labor epidural, placement of lines and epidurals in the holding areas as noted in previous slide
  • Can’t do an ECT
• Go down the hall and see a patient in the pain clinic
• Go outside the immediate area to deliver a lecture
• Go out to extended lunch and leave area
Definition of Immediately Available When Medically Directing

Committee of Origin: Economics : Approved by the ASA House of Delegates on October 17, 2012

• A medically directing anesthesiologist is immediately available if s/he is in physical proximity that allows the anesthesiologist to return to re-establish direct contact with the patient to meet medical needs and address any urgent or emergent clinical problems. These responsibilities may also be met through coordination among anesthesiologists of the same group or department.

• Differences in the design and size of various facilities and demands of the particular surgical procedures make it impossible to define a specific time or distance for physical proximity.
Working With CRNA

Anesthesia by a CRNA with Medical Direction:

- For physician billing, the 7 rules of medical direction must be met and the physician must be immediately available for each case. The CRNA would bill for time and units with a QX modifier and the physician would bill for the same codes with a QK modifier.
Working With Student CRNA’s

Anesthesiologist and Student CRNAs:
An anesthesiologist can work with no more than two SRNAs who are not providing services with a CRNA and bill services. As medical direction (QK modifier) for their service with no SRNA billing.

Teaching CRNAs and Student CRNAs: Medicare Claims Processing Manual -- Section 140.5

• A teaching CRNA when being medically directed can supervise a SRNA in their case and bill with the QY and the anesthesiologist with the QK modifier for 50% each of the fee schedule.
Separate Procedures: Line Placements etc.

• Procedure would be separately billable by the TP if the TP was present for the entire procedure or the key and critical portions of the procedure performed by a resident or fellow and the TP documents their presence.

• If the CRNA performed the procedure, the procedure should be billed under the CRNA.
Canceled Anesthesia

• If case canceled prior to induction, bill for pre-op assessment with 99231-99233, as supported by documentation standards.

• If case is canceled after induction, bill applicable surgical anesthesia code with base units + time with -53 modifier.
Local Coverage Determinations (LCDs) –

National Coverage Determinations (NCDs) and

Medical Necessity
Local Coverage Determination (LCD): Monitored Anesthesia Care (L35049)

Select the Print Complete Record, Add to Basket or Email Record Buttons to print the record, to add it to your basket or to email the record.

Printing Note:
To print an entire document, including all codes in all code groups, use the Need a PDF Button or the Print Complete Record Button.

To print only the current visible page contents, use the Print Button in the page header.
LCD - What is a MAC Level of Service

During MAC, the patient’s oxygenation, ventilation, circulation and temperature should be evaluated by whatever methods are deemed most suitable by the attending anesthetist.

Close monitoring is necessary to anticipate the need for general anesthesia administration or for the treatment of adverse physiologic reactions such as hypotension, excessive pain, difficulty breathing, arrhythmias, adverse drug reactions, etc.

In addition, the possibility that the surgical procedure may become more extensive and/or result in unforeseen complications requires comprehensive monitoring and/or anesthetic intervention.
What is MAC?

According to The American Society of Anesthesiologists:

• MAC can be distinguished from Moderate Sedation in several ways. An essential component of MAC is the anesthesia assessment and management of a patient’s actual or anticipated physiological derangements or medical problems that may occur during a diagnostic or therapeutic procedure.

• While MAC may include the administration of sedatives and/or analgesics often used for Moderate Sedation, the provider of MAC must be prepared and qualified to convert to general anesthesia when necessary.

• Additionally, a provider’s ability to intervene to rescue a patient’s airway from any sedation-induced compromise is a prerequisite to the qualifications to provide Monitored Anesthesia Care.
  • By contrast, Moderate Sedation is not expected to induce depths of sedation that would impair the patient’s own ability to maintain the integrity of his or her airway. These components of Monitored Anesthesia Care are unique aspects of an anesthesia service that are not part of Moderate Sedation.
Special Conditions or Criteria Must be Supported by Documentation in the Medical Record.

• Reimbursement for MAC is the same amount allowed for full general anesthesia services if all requirements are met.

• The provision of quality MAC requires the same expertise and the same effort (work) as required in the delivery of a general anesthetic. If the requirements are not fulfilled or the procedures are unnecessary, payment will be denied in full.

• For procedures that do not usually require anesthesia services, MAC could be covered when the patient’s condition requires the presence of qualified anesthesia personnel to perform monitored anesthesia in addition to the physician performing the procedure, and is so documented in the patient’s medical record.

• The presence of an underlying condition alone, as reported by an ICD-10-CM diagnosis code, may not be sufficient evidence that MAC is necessary. The medical condition must be significant enough to impact on the need to provide MAC such as the patient being on medication or being symptomatic, etc. The presence of a stable, treated condition, of itself, is not necessarily sufficient.
MAC Versus General ??

• General anesthesia (GA) is the state produced when a patient receives medications for amnesia, analgesia, muscle paralysis, and sedation. An anesthetized patient can be thought of as being in a controlled, reversible state of unconsciousness. Anesthesia enables a patient to tolerate surgical procedures that would otherwise inflict unbearable pain, potentiate extreme physiologic exacerbations, and result in unpleasant memories.

• General anesthesia has many purposes including:
  • pain relief (analgesia)
  • blocking memory of the procedure (amnesia)
  • producing unconsciousness
  • inhibiting normal body reflexes to make surgery safe and easier to perform
  • relaxing the muscles of the body

• The combination of anesthetic agents used for general anesthesia often leaves a patient with the following clinical constellation: [1]
  • Unarousable even secondary to painful stimuli
  • Unable to remember what happened (amnesia)
  • Unable to maintain adequate airway protection and/or spontaneous ventilation as a result of muscle paralysis
  • Cardiovascular changes secondary to stimulant/depressant effects of anesthetic agents
CONTINUUM OF DEPTH OF SEDATION:
DEFINITION OF GENERAL ANESTHESIA AND LEVELS OF SEDATION/ANALGESIA*

Committee of Origin: Quality Management and Departmental Administration

(Approved by the ASA House of Delegates on October 13, 1999, and last amended on October 15, 2014)

<table>
<thead>
<tr>
<th></th>
<th>Minimal Sedation</th>
<th>Moderate Sedation/ Analgesia</th>
<th>Deep Sedation/ Analgesia</th>
<th>General Anesthesia</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Anxiolytics</td>
<td>(&quot;Conscious Sedation&quot;)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Responsiveness</strong></td>
<td>Normal response to verbal or tactile stimulation</td>
<td>Purposeful** response to verbal or tactile stimulation</td>
<td>Purposeful** response following repeated or painful stimulation</td>
<td>Unarousable even with painful stimulus</td>
</tr>
<tr>
<td><strong>Airway</strong></td>
<td>Unaffected</td>
<td>No intervention required</td>
<td>Intervention may be required</td>
<td>Intervention often required</td>
</tr>
<tr>
<td><strong>Spontaneous</strong></td>
<td>Unaffected</td>
<td>Adequate</td>
<td>May be inadequate</td>
<td>Frequently inadequate</td>
</tr>
<tr>
<td><strong>Ventilation</strong></td>
<td>Unaffected</td>
<td>Usually maintained</td>
<td>Usually maintained</td>
<td>May be impaired</td>
</tr>
<tr>
<td><strong>Cardiovascular</strong></td>
<td>Unaffected</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Function</strong></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Minimal Sedation (Anxiolytics) is a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and physical coordination may be impaired, airway reflexes, and ventilatory and cardiovascular functions are unaffected.

Moderate Sedation/Analgesia ("Conscious Sedation") is a drug-induced depression of consciousness during which patients respond purposefully** to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

* Monitored Anesthesia Care ("MAC") does not describe the continuum of depth of sedation, rather it describes "a specific anesthesia service in which an anesthesiologist has been requested to participate in the care of a patient undergoing a diagnostic or therapeutic procedure."

** Reflex withdrawal from a painful stimulus is NOT considered a purposeful response.
Deep Sedation/Analgesia is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully** following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

General Anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function 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.

Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to rescue*** patients whose level of sedation becomes deeper than initially intended. Individuals administering Moderate Sedation/Analgesia ("Conscious Sedation") should be able to rescue*** patients who enter a state of Deep Sedation/Analgesia, while those administering Deep Sedation/Analgesia should be able to rescue*** patients who enter a state of General Anesthesia.

** Reflex withdrawal from a painful stimulus is NOT considered a purposeful response.

*** Rescue of a patient from a deeper level of sedation than intended is an intervention by a practitioner proficient in airway management and advanced life support. The qualified practitioner corrects adverse physiologic consequences of the deeper-than-intended level of sedation (such as hypoventilation, hypoxia and hypotension) and returns the patient to the originally intended level of sedation. It is not appropriate to continue the procedure at an unintended level of sedation.
Obstetric Procedures

• Anesthesia services consist of the administration of an anesthetic agent to produce either a partial or complete loss of sensation.

• Clear documentation of any visits/evaluations/encounters with the patient by the anesthesiologist or anesthetist during labor and/or delivery must be noted in the medical record and must be available if requested.

• This includes, but is not limited to:
  • documentation of catheter placement(s),
  • administration of medications,
  • visits to assess effectiveness of analgesia
    • There are no specific guidelines from ASA or CMS to indicate how frequently the practitioner must see the patient. The organization must set standards to meet the medical necessity for the service.
  • attendance at delivery, and
  • post-partum follow-up care.
Obstetrics Code 01967

Neuraxial analgesia/anesthesia for planned vaginal delivery (See ASA guide for appropriate reporting code 01967): “epidural – spinal”

1. Report up to 60 minutes of time for epidural catheter insertion and removal and delivery.
   • Note: These 60 minutes may be used at the discretion of the anesthesiologist. If either the insertion/removal of the epidural catheter and/or the delivery, individually or combined, exceeds the 60 minute threshold, additional time may be reported provided the medical record documentation supports the need for additional time.

2. Report 15 minutes of time for each hour patient is in labor. A notation must be made in the medical record, signed by the anesthesiologist or CRNA, which confirms each time they visited the laboring patient during labor (a short progress note is acceptable for this notation).

3. Report actual time, in minutes, for time spent with the patient for the management of complications or adverse events, provided that actual care time is fully documented in the medical record.

NOTE: This code is used for all vaginal deliveries and associated labor, and the labor portion of deliveries that are accomplished by Cesarean section.
Billing Guidelines for Code 01967

Neuraxial Labor Analgesia Reimbursement Calculations

Report total minutes and start and stop times.

• Neuraxial labor analgesia (CPT code 01967) is based on Base Unit Value plus Time Units subject to a cap of 435 minutes.

• Modifying Units for physical status modifiers and qualifying circumstance codes will be considered in addition to the Base Unit Value for labor or delivery anesthesia services in accordance with the Standard Anesthesia Formula.
Add-on Codes Obstetrics

Two labor anesthesia add-on codes:

• +01968 - Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia (list separately in addition to code for primary procedure performed)

• +01969 - Anesthesia for cesarean hysterectomy following neuraxial labor analgesia/anesthesia (List separately in addition to code for primary procedure performed)

Remember: Report these codes as appropriate in conjunction with 01967. Primary code 01967 is 5 base units; add 3 additional units for 01968 or 5 more units for 01969, then report the total time represented by both codes.

Medicare requires for the obstetrical add-on codes, that the anesthesia time be separately reported with each of the primary and the add-on codes based on the amount of time appropriately associated with either code. Both the base unit and the time units for the primary and the add-on obstetrical anesthesia codes are recognized.
Questions That Will Be Followed-up On

• What is the process for anesthesia consultation billing in the following situations:
  • In person history and physical examination, patient with Cerner MRN
  • In person history and physical examination, patient without Cerner MRN
  • Phone history patient with Cerner MRN
  • Phone history patient without Cerner MRN

• High risk obstetric patients are referred for OB anesthesiology consultation during their pregnancy. Several scenarios may occur
  • We see the patient at JMH. She has a Cerner MRN.
  • We see the patient at JMH. Her prenatal care, however, is only through UM (medical records are in UChart only). She does not have a Cerner MRN when we evaluate her.
  • The patient does not come to see us prior to presenting in labor or presenting for scheduled cesarean delivery, so we interview her via phone. She does have a Cerner MRN.
  • The patient does not come to see us prior to presenting in labor or presenting for scheduled cesarean delivery, so we interview her via phone. She does not have a Cerner MRN.
Critical Care: Medical Review Guidelines

• **Clinical Criterion** – A high probability of sudden, clinically significant or life threatening deterioration of the patient's condition which requires a high level of physician preparedness to intervene urgently

• **Treatment Criterion** – Life or organ supporting interventions that require frequent assessment and manipulation by the physician.
  • Withdrawal of or failure to initiate these interventions would result in sudden, clinically significant / life-threatening deterioration in the patient’s condition.

• **Time spent teaching or by residents may not be used in CC time and NPP time cannot be added to physician time.**

Providing medical care to a critically ill, injured, or post-operative patient qualifies as a critical care service only if both the illness or injury and the treatment being provided meet the requirements.
CC Codes 99291 and 99292

<table>
<thead>
<tr>
<th>Time</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 30 min</td>
<td>Appropriate E/ M code</td>
</tr>
<tr>
<td>30-74 min</td>
<td>99291 x 1</td>
</tr>
<tr>
<td>75-104 min</td>
<td>99291 x 1 and 99292 x 1</td>
</tr>
<tr>
<td>105-134 min</td>
<td>99291 x 1 and 99292 x 2</td>
</tr>
<tr>
<td>135-164 min</td>
<td>99291 x 1 and 99292 x 3</td>
</tr>
</tbody>
</table>
Critical Care Documentation & Criteria
MM5993 Related Change Request Number: 5993

• The TP documentation must include:
  • Time the teaching physician spent providing critical care (resident time and
time teaching residents does not count toward the 30 minute minimum);
  • That the patient was critically ill during the time the TP saw the patient (met
clinical criterion of a high probability of sudden, clinically significant or life
threatening deterioration of the patient's condition);
  • What made the patient critically ill; and
  • The nature of the treatment and management provided by the TP (treatment
criterion of Life or organ supporting interventions that require frequent
assessment and manipulation by the physician.)

• Combination of the TP's documentation and the resident’s may support CC
provided that all requirements for CC services are met. The TP documentation
may tie into the resident's documentation. The TP may refer to the resident’s
documentation for specific patient history, physical findings and medical
assessment as long as additional TP documentation is included to support their
CC time.
Critical Care Working With MD and NPP

Time from the NPP and Attending Physician cannot be added together for critical care. If the NPP provides and documents CC they bill the CC codes under their own name and number.

- If the physician provides CC and the NPP does not provide CC but provides a medically necessary service, the NPP bills a subsequent hospital visit.
- If neither the NPP or Attending documents CC to bill, their services are combined as a shared visit with one subsequent hospital visit.

FAQ 1: If critical care was provided by a nurse practitioner without physician involvement, can the nurse practitioner bill critical care?

A: Yes, if the service provided is within the scope of practice the NP’s services would be billed under the NP’s NPI number.

FAQ 2: Can a physician and a nurse practitioner combine their time for billing critical care?

No. Critical care services cannot be billed as a shared/split service. The MD and NP time cannot be combined to meet critical care billing requirements. If each provided at least 30 minutes and the time exceeded 74 minutes, one provider could bill 99291 and the other 99292.
JCAHO Timeout Handout
I wrote down the wrong diagnosis—what’d you do?
Interactions with Health Industry Entities Policy (Conflict of Interest)

Purpose:
• To set the standards for vendor interactions with healthcare professionals.
• To avoid Conflict of Interests and disclose all activities that could perceived as conflictive in nature.

Highlights:
• Restrictions on Industry Representatives on-site
• Presentations by Vendors
  o Valuable scientific and educational benefits
  o No industry sponsored lunches for product marketing
• Restrictions on financial support for CME
• Consulting arrangements
  o Disclosure requirements (must follow UM consulting policy)
• Educational Presentations
  o Content/sponsorship requirements
  o Approval process
• **No** product samples (*drugs, medical devices, or any other products*) can be accepted by faculty, staff, or students
• Independence of decision-making
HIPAA, HITECH, PRIVACY AND SECURITY

• HIPAA, HITECH, Privacy & Security Health Insurance Portability and Accountability Act – HIPAA
  – Protect the privacy of a patient’s personal health information
  – Access information for business purposes only and only the records you need to complete your work.
  – Notify Office of HIPAA Privacy and Security at 305-243-5000 if you become aware of a potential or actual inappropriate use or disclosure of PHI, including the sharing of user names or passwords.
  – PHI is protected even after a patient’s death!!!

• Never share your password with anyone and no one use someone else’s password for any reason, ever – even if instructed to do so.

✓ If asked to share a password, report immediately.
✓ If you haven’t completed the HIPAA Privacy & Security Awareness on-line CBL module, please do so as soon as possible by going to:

http://www.miami.edu/index.php/professional_development_training_office/learning/ulearn/
HIPAA, HITECH, Privacy & Security

Several breaches were discovered at the University of Miami, one of which has resulted in a class action suit. As a result, “Fair Warning” was implemented.

What is Fair Warning?

• Fair Warning is a system that protects patient privacy in the Electronic Health Record by detecting patterns of violations of HIPAA rules, based on pre-determined analytics.
• Fair Warning protects against identity theft, fraud and other crimes that compromise patient confidentiality and protects the institution against legal actions.
• Fair Warning is an initiative intended to reduce the cost and complexity of HIPAA auditing.

UHealth has policies and procedures that serve to protect patient information (PHI) in oral, written, and electronic form. These are available on the Office of HIPAA Privacy & Security website: http://www.med.miami.edu/hipaa
Available Resources at University of Miami, UHealth and the Miller School of Medicine

- If you have any questions or concern regarding coding, billing, documentation, and regulatory requirements issues, please contact:
  - **A. Barry Grosse, JD – Chief Compliance Officer**
    - **Phone:** (305) 243-6000
  - **Iliana De La Cruz, RMC, Executive Director, Professional Billing Compliance**
  - **Gema Balbin-Rodriguez, Director, Professional Billing Compliance**
    - **Phone:** (305) 243-5842
    - **Email:** Officeofbillingcompliance@med.Miami.edu

Also available is The University’s fraud and compliance hotline via the web at [www.canewatch.ethicspoint.com](http://www.canewatch.ethicspoint.com) or toll-free at 877-415-4357 (24 hours a day, seven days a week). Your inquiry or report may remain anonymous.

- Office of billing Compliance website: [www.obc.med.miami.edu](http://www.obc.med.miami.edu)