How do Anesthesiologists get paid? Anesthesia Billing and Compliance

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Goal

To understand the intricacies of documentation, requirements for care, and the need for optimization of revenue capture for Anesthesia related services

How do Anesthesiologists get paid?

Agenda

1. Fee for Service
    - Anesthesia Billing (Time-based billing)
    - Procedural Billing
    - E/M Billing
2. Quality Payment Program (QPP)
    - Merit-based Incentive Payment System
    - Advanced Alternative Payment Models (APM)
        - Advanced APM
        - MIPS APM
3. Billing Errors, Fraud, and Abuse
4. Payment for Services (Support / Investment)

Fee for Service

Traditional CMS and Third-Party Payer Methodology – RVU Methodology

Time Based Billing – Anesthesiology Billing is Primarily Time-Based Billing

Procedure Based Billing – Central Lines / Arterial Lines / etc.

Evaluation and Management Billing – Consults, Pain Management, Follow-up Billing

Qualifying Anesthesia Service

Required elements:

Pre-anesthetic Evaluation

Anesthetic Documentation

Post-anesthesia Evaluation

Qualifying Anesthesia Service Pre-Anesthesia Evaluation

482.52 – Pre-anesthesia Evaluation

"A pre-anesthesia evaluation completed and documented by an individual qualified to administer anesthesia performed within 48 hours prior to surgery or procedure requiring anesthesia services" – ***performed and documented prior to dosing of drugs intended for induction***

Must include:

- Review of medical history including anesthesia, drug, and allergy history
- Interview and examination of the patient

These two elements must be performed within 48hours prior

- Data applicable and as required by standards of anesthesia care – EKG, labwork, etc
- Notation of anesthesia risk
- Identification of potential anesthesia problems
- Development of an anesthesia plan including postoperative care and discussion of patient of risks and benefits

These four elements must be reviewed within 48 hours but may be documented up to 30 days prior

Qualifying Anesthesia Service
Post Anesthesia Evaluation

482.52(c) – Post Anesthesia Evaluation

"A post anesthesia evaluation completed and documented by an individual qualified to administer anesthesia no later than 48 hours after surgery or procedure requiring anesthesia services" (24 hours PADOH)

Must include:

- Respiratory function
  (rate, airway patency, 02 sat)
- Cardiovascular function
  (pulse rate and BP)
- Mental status
- Temp
- Pain
- Nausea/ Vomiting
- Postop hydration status

"48 hour period begins when patient is moved into designated recovery area." "Evaluation should not begin until sufficiently recovered from acute administration of anesthesia so as to participate."

If unable to participate, documentation Includes reason and expected recovery timeframe

Payment for Anesthesia Services

General Payment Rule:

“Based on allowable base and time units multiplied by an anesthesia conversion factor specific to that locality”

Payment for Anesthesia Services

Anesthesia is a professional service billed using the CMS-1500 claim form

Anesthesia claim is calculated as follows:

- ***Base Units*** (CMS/ASA assigned values for each procedure)

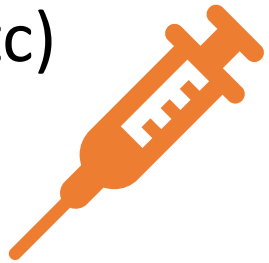
  Plus

- ***Time Units*** (actual anesthesia time as calculated by a start and stop time)

  Plus

- ***Special Units*** (modifying units such as age, patient condition, etc)

Multiplied by an "Anesthesia Conversion Factor"



Base Units

Base Units

All Surgical/Procedural CPT codes have an associated Anesthesia Base Unit

Base Units consider complexity of procedure and cost associated with that complexity

Base Units

CPT Code	Procedure		Base Units
00520	ANES FOR CLOSED CHEST PROC; (INCLUDING BRONCHOSCOPY);		6
00522	ANES FOR CLOSED CHEST PROCE; (INCLUDING BRONCHOSCOPY); needle bx		4
00528	ANES FOR CLOSED CHEST PROC; MEDIASTINOSCOPY		8
00530	ANES FOR PERMANENT TRANSVENOUS PACEMAKER		4
00537	ANES FOR CARDIAC ELECTROPHYSIOLOGIC PROCEDURES		10
00539	ANES FOR TRACHEOBRONCHIAL RECONSTRUCTION		18
00540	ANES FOR THORACOTOMY INV LUNGS, PLEURA		12
00542	ANES FOR THORACOTOMY PROC, DECORTICATION		15

Base Units

Includes integral parts of the anesthesia service. Included in the “base units” and cannot be billed separately:

- Positioning
- Placement of monitors (including special monitors, EEG, etc.)
- Placement of peripheral lines
- Placement of Airway, NG tubes, etc.
- Intra-operative interpretation of monitored functions
- Interpretation of labs
- Nerve stimulation
- Insertion of foley catheter
- Blood sampling, etc.

Payment for Anesthesia Services

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  Plus
- ***Time Units*** (actual anesthesia time as calculated by a start and stop time)
  Plus
- ***Special Units*** (modifying units such as age, patient condition, etc)

Multiplied by Anesthesia Conversion Factor

Time Units

Anesthesia Time and Calculation of Anesthesia Time Units

Definition of Anesthesia Time:

“Defined as the period during which an anesthesia practitioner is present with the patient. It starts when the anesthesia practitioner begins to prepare the patient for anesthesia and ends when the anesthesia practitioner is no longer furnishing anesthesia services, that is, when the patient may be placed safely under postoperative care.”

Time Units

Must be reported in actual minutes and supported by the documentation in the record

- Document transfer time to recovery room or ICU personnel
- Time stops if “qualified anesthesia provider” is not with patient –ie. A holding area nurse, circulating nurse, or medical student is NOT a “qualified anesthesia provider”
- DO NOT round time up or down
- DO NOT add time units

False Claim

One time unit for each 15 minute interval or fraction thereof

117 minutes = 7.8 time units

- Pre-op and Post-op visit time is INCLUDED in the BASE units

Time Units

Discontinuous Time:

Blocks of time can be added around an interruption in anesthesia time as long as practitioner is furnishing continuous anesthesia care within the time periods around the interruption.

Example:

Preparing a patient for the procedure and the surgeon calls informing the OR he will be late

Placement of Stereotactic Frame in Holding Area

Time Units

Discontinuous Time

- Anesthesia record must clearly show each start and stop time
- Total time billed must match time reflected in anesthesia record

Payment for Anesthesia Services

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  Plus

- ***Time Units*** (actual anesthesia time as calculated by a start and stop time)

  Plus

- ***Special Units*** (modifying units such as age, patient condition, etc)

Multiplied by Anesthesia Conversion Factor

Special Units or Modifying Units

Additional Units that may be added to total units if certain conditions are met:

99100 – Extreme Age – under 1 year or over 70yrs – 1 unit

99116 – Anesthesia with total body hypothermia – 5 units

99135 – Anesthesia with controlled hypotension – 5 units

99140 – Anesthesia complicated by Emergency – 2 units

Medicare and Medicaid Only Pay for Base and Time Units

Emergency = “delay in treatment would lead to significant increase in threat to life or body part”

Special Units or Modifying Units

Physical Status Modifying Units:

- P1 – a normal healthy patient – zero units
- P2 – Patient with mild systemic disease – zero units
- P3 – Patient with severe systemic disease – one unit
- P4 – Patient with severe systemic disease that is a constant threat to life – two units
- P5 – A moribund patient not expected to survive the operation – three units
- P6 – A declared brain-dead patient for organ harvest – zero

Medical condition supporting documentation must be present on record

Medicare and Medicaid Only Pay for Base and Time Units

Payment for Anesthesia Services

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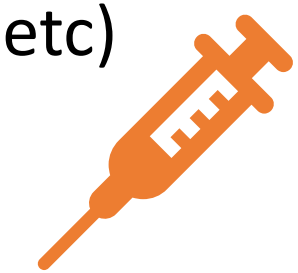
Multiplied by Anesthesia Conversion Factor



Conversion Factor (CF)

Contractor	Locality	Locality Name	2020 Work GPCI	2020 PE GPCI	2020 MP GPCI	National Anes CF of 21.5600
12502	01	METROPOLITAN PHILADELPHIA	1.022	1.083	1.199	22.47
12502	99	REST OF PENNSYLVANIA	1.000	0.939	0.888	21.21

PA Medicaid = $17.04

Locale adjusted rate per unit approved by CMS 2021

CF for Western PA = $21.21 (2011 21.17) – 0.14%

Philadelphia = $22.47

Alaska = $29.88

Queens = $25.46

NYC SUBURBs = $25.33

Nebraska = $20.24

Increase Expense
2011-2021
CRNA FTE – 30%
MD FTE – 17%

Average Commercial Rate per ASA unit approximately $65

Projected Reimbursement

Lumbar Lami, Exc.Herniated Disk, Instrumentation, Fusion

CPT codes 63030, 22840, and 22612

ASA codes 00630 and 00670

- ASA base units:
  - 00630 = Lumbar Lami (63030) & Fusion (22612)= 8 units
  - 00670 = Instrumentation (22840) = 13 units
- Time units: 3 Hour case = 12 units (each 15 min = 1 unit)
- Total units:
  - 00630=20 units (8 base + 12 time) Lami/Fusion – Medicare $424, Best Commercial $1640
  - 00670=25 units (13 base + 12 time) Instrumentation –Medicare $530, Best Commercial$2050

Documentation MATTERS!!

Projected Reimbursement

Documentation CRITICAL to optimize coding:

- Spinal Procedures with instrumentation
  - Must be documentation of “cages, hooks, pedicle fixation, plating, rods, screws, wires” – add 3 -5 base units – 90% of spinal surgeries involve instrumentation
- Approach – Thoracic vs. Abdominal for Esophagectomy
- Position
  - Other than supine can add up to five additional base units – cervical spine sitting vs. other = 3 additional units
- Site
  - Proper documentation may allow up to 2 additional units – upper two thirds femur vs. lower one-third femur – one additional unit

Allowable Reimbursement

(Base Units + Time Units + Special Units)

Times Conversion Factor

= “Allowable Reimbursement”

Note: Allowable reimbursement does not mean this is what we get paid –

third party payer rules / contracts determine payment

Projected Reimbursement

Example:

01967 Vaginal Delivery (5 base + 8 time units) X 21.21 = $275.73

- Anesthesia
  codes only
- All service
- 15 minute
- Anesthesia
  an AA prici
- Anesthesia
  should be
  to the Ame
  specificatio

Code	Brief Description	Basic Values	Guidelines
01967	Neuraxial labor analgesia/anesthesia for planned vaginal delivery (this includes any repeat subarachnoid needle placement and drug injection and/or any necessary replacement of an epidural catheter during labor)	5	One unit is allowed for each 30-minute increment of time.
+ 01968	Anesthesia for cesarean delivery following neuraxial labor	3	One unit is allowed for each 15-minute increment of time.
+01969			

2) **Continuous Epidural Analgesia for Labor and Delivery** 01960, 01961, 01967, 01968, 01969, 62319
   a) For a vaginal delivery, code 01967 has been added to the Procedure Tiers in Facets to allow one unit only. The code will be priced per the R&C schedule and automatically price one unit.
   b) For a vaginal delivery that turns into a Cesarean (C-section) using an epidural, use code 01967 which will price per the R&C Schedule and code 01968 (3 ASA units) plus the actual time units for the Cesarean.
   c) For a scheduled/planned Cesarean delivery using an epidural, use code 01961 (7 ASA units). This would allow the ASA value of 7 units plus the actual time units for the surgery.

NOTE: 62319 is not to be used with the above coding since the anesthesia code includes the insertion of the epidural.

Procedure Code	
01960	Anesthesia
01967	Neuraxial planned va
01961	Anesthesia
01968	Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia

Payment for Anesthesia Services Anesthesiologist

Payment as Personally Performed (AA) – 100% of Allowable

Payment as Medically Directed (QK,QY)– 50 or 100% of Allowable

Payment as Medically Supervised (AD) – 3 units plus one additional unit if present for induction

Payment for Anesthesia Services Anesthesiologist AA

Payment at Personally Performed Rate – 100% of allowable

- Physician personally performs entire anesthesia service
- Physician is involved in the training of physician residents in a single anesthesia case, two concurrent cases involving residents, or a single anesthesia case involving a resident that is concurrent to another case billed under medical direction rules – Physician must meet teaching physician criteria
- Physician is *continuously* involved in a single case involving a student nurse anesthetist
- The physician and CRNA (or AA) are involved in one anesthesia case and the services of each are found to be medically necessary – documentation supports

Payment for Anesthesia Services Anesthesiologist – QY, QK

Medical direction of 2-4 (QK) – 50% of Allowable

- Physician medically directs up to 4 "qualified individuals" AND performs the following activities:
  - Performs a pre-anesthetic examination and eva
  - Prescribes the anesthetic plan
  - Personally participates in the most demand pro including induction and emergence
  - Ensures that any procedures in the anesthetic p n are performed by a qualified personnel
  - Monitors the course of the anesthesia administ
  - Remains physically present and available for immediate diagnosis and treatment of emergencies
  - Provides indicated-post-anesthesia care.
- Medical Direction of 1 (QY) w/ medical necessity to be present – 100% Allowable

Anesthesiologist must personally document each of these requirements in the anesthetic record

Payment for Anesthesia Services Anesthesiologist

Medically Directing Anesthesiologist may perform other duties concurrently:

- Addressing an emergency of short duration in the immediate area
- Administer an epidural or caudal anesthetic to a patient in labor
- Perform periodic monitoring of an obstetrical patient
- Check on or discharge patients in the PACU
- Coordinate scheduling matters
- Receive patients entering suite for the next surgery

Note – this list appears in federal register, clarification in FAQ sessions by CMS Administrator in our area expands the list considerably

Payment for Anesthesia Services Anesthesiologist

IF concurrency exceeds 4 ***OR*** ALL ELEMENTS noted in previous slide not performed defaults to Medical Supervision

Medical Supervision (AD) = 3 units plus 1 if present for induction

Concurrency = maximum number of procedures that the physician is medically directing in context to a single procedure

Any overlap by a single case can increase concurrency exceeding Medical Direction and impact ALL concurrent cases

Resident Cases

- Concurrency limited to 2:1
  - ACGME Required and Billing Implications
  - Two Residents – both cases billed as “Personally Performed” if teaching rules met
  - CRNA and Resident – CRNA case billed as Medically Directed, Resident Case billed as “Personally Performed”

Teaching Requirements:

“To qualify for payment, the teaching anesthesiologist, or different anesthesiologists in the same anesthesia group, must be present during all critical or key portions of the anesthesia service or procedure involved. The teaching anesthesiologist (or another anesthesiologist with whom the teaching physician has entered into an arrangement) must be immediately available to furnish anesthesia services during the entire procedure. The documentation in the patient’s medical records must indicate the teaching physician’s presence during all critical or key portions of the anesthesia procedure and the immediate availability of another teaching anesthesiologist as necessary.”

Payment for Anesthesia Services Hand-On Provider

- Third party payer contracts will determine level of reimbursement for non-CMS
- Medicaid – no payment for CRNAs, 100% first medically directed, 25% second, 0% after
- Commercial - may only pay 50% for CRNAs regardless of modifier

Modifier	Description	% of Allowable
GC	Resident Service, Direction of Teaching Anesthesiologist	
QX	CRNA/AA Service, Medical Direction Physician	50 -100%
QZ	CRNA Service, Without Medical Direction by Physician	100%

Examples: Medical Direction with CRNA both Anesthesiologist and CRNA bill QK each receives 50% of allowable Teaching Anesthesiologist with a Resident and 2 room max concurrency– billed AA-GC – Anesthesiologist receives 100% of allowable, if concurrency w/ resident 3 or 4 - billed QK-GC - Anesthesiologist receives 50% allowable

Resident Cases

Example:

1/26/14 Case 1 Resident 06:36 – 15:04 **57 unit** Case

PUH Case 2 CRNA 12:35 – 13:48

Case 3 CRNA 13:47 – 15:43

Revenue impact from 1 minute overlap = $1050 (Average Payer)

$2500 (Best Payer)

Monitored Anesthesia Care

MAC services only payable if medically reasonable and necessary and intra-operative monitoring are documented on the chart

Covered procedures determined by Local Coverage Determination (LCD)

Other procedures MAY be allowable with documentation via ICD-10 code or other medical necessity

Bottom line – for many cases, support for MAC must be in documentation

All requirements for Anesthesia must be met

Anesthesia Modifiers - MAC

Modifier	Description	% Allowable
-OS	Monitored Anesthesia Care Services	0 – 100%
-G8	MAC for deep complex, complicated or markedly invasive surgical procedures	100%
-G9	MAC for patient who has a history of severe cardiopulmonary condition	100%

Documentation must support

Procedure Based (Type 2) Billing

CMS Relative Value Units (RVU)

Centers for Medicare and Medicaid Services assign RVU value to every surgical CPT procedure code

Considers cost of various components for the procedure

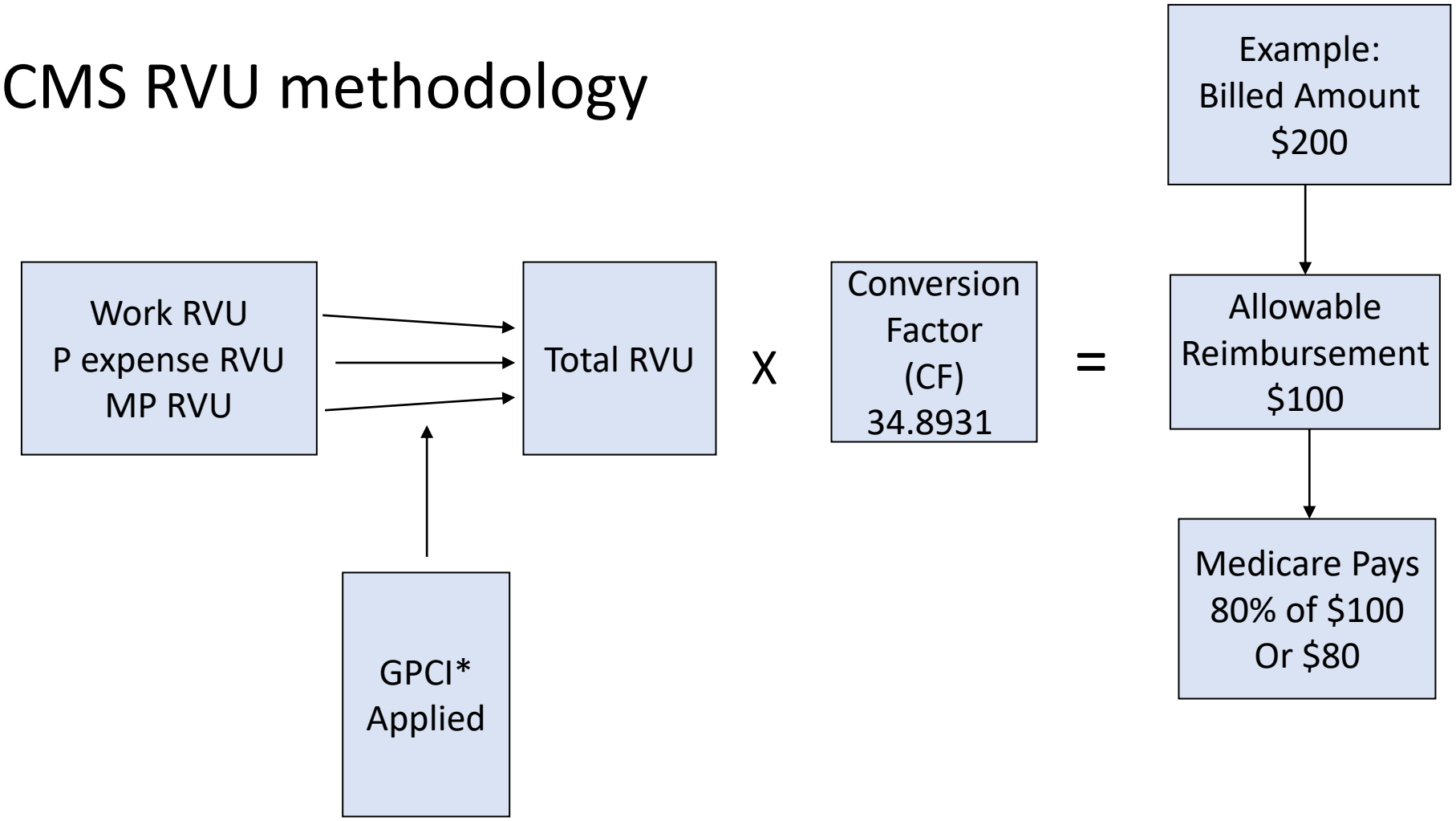
All federally sponsored and most insurance companies utilize RVUs when determining reimbursement

Flat-fee for service based on CPT code

- No time associated with these charges
  - Arterial Lines
  - CVPs
  - Swan-Ganz Catheters
  - Pain Blocks
  - TEE

Procedure Based (Type 2) Billing

CMS RVU methodology



*Geographic Practice Cost Indices

20% Coinsurance Patient Responsibility (or Medigap or Part C Advantage Plans)

Evaluation and Management Billing (E/M Coding)

Unlike Anesthesia Services (Time-Based Billing) Pain Billing utilizes Evaluation and Management Billing (E/M) and Procedural Based (CPT/RVU)

- Consultation – E/M
- Intervention – Procedural Based
- Follow-up – E/M

E/M Services Consultations

Consultation for pain management are allowable services, must meet the following requirements:

- Referring physician must request an opinion regarding management of a specific problem (ie. Foot pain post foot surgery)
- The referring physicians request and need for consultation must be documented in the medical record
- The consultant must prepare a written report of his/her findings which is provided to the referring physician

Consult Documentation

Must meet requirements for health care payers to validate “site of service, medical necessity, and appropriateness of diagnostic or therapeutic services required”

1. Requesting Physician
2. Reason for Consultation – must be a ICD-10 pain code
3. History
4. Review of Systems
5. Examination
6. Assessment and Plan – ie. Medical Decision Making

CMS no longer utilizes “consult codes” but many third party payers do – code selected based on level of service

AIPPS – Interventional Nerve Block

Procedural Based Billing - CMS Relative Value Units (RVU)

Centers for Medicare and Medicaid Services assign a RVU value to every CPT procedure code

Considers cost of various components for the procedure

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Special Coding Issues – Interventional Block for Post-op Pain

Post-operative pain service can be reported and billed separately if two conditions are met:

- It MUST be performed outside of anesthesia time
- Surgeon must document in the medical record medical necessity

"Medical Necessity" – "standards of good medical practice *in the local area"*

"New" Pain Blocks Without Specific CPT codes billed as "other block" – most third-party payers will not reimburse – must work with payers

AIPPS – Interventional Nerve Block

Table 6.2. Center for Medicare and Medicaid Services example of Current Procedural Terminology codes and associated relative value units in 2008, 2010 and 2012.

Site	CPT code	RVU (2008)	RVU (2010)	RVU (2012)	RVU 21
Single-shot block codes					
Brachial plexus	64415	1.87	1.98	1.94	1.84
Axillary	64417	1.87	1.94	2.12	1.77
Femoral	64447	1.76	1.84	1.97	1.54
Continuous nerve block codes					
Brachial plexus	64416	4.62	2.27	2.37	1.88
Femoral	64418	3.93	2.24	2.13	1.68
Lumbar plexus	64449	3.81	2.29	2.48	1.82

CPT: Current Procedural Terminology; RVU: Relative value unit.

Hudson ME Future Med 2014: 68-80.

AIPPS – Interventional Nerve Block

Documentation of Nerve Block

- Referring Physician
- ICD Pain Code
- Documentation of protocol for wrong site procedure prevention
- Site of the Nerve Block
- Localization Techniques
- Medications used
- Complications
- Provider Details

Teaching Attestation if Performed By a Trainee

Standardized separate nerve block procedure note provides documentation separate from anesthetic record, includes required documentation elements, a guide for selection of appropriate CPT code

-59 Modifier separates the procedure code from the surgical anesthesia service

AIPPS – Interventional Nerve Block

Multiple Nerve Blocks Coded with Modifiers:

-51 – Multiple blocks, additional blocks billed at 50%

-50 – Bilateral blocks, additional blocks billed at 50%

Optimization of revenue requires that the highest RVU block be billed as the primary block.

Example – Continuous Sciatic with Single Shot Femoral

Fully bill Sciatic Continuous (64446-59) with the Femoral block billed with modifier – 51 (64447-59,51)

AIPPS – Ultrasound Guidance

Ultrasound guidance separately billable with specific documentation requirements – CPT 76942 “ultrasound guidance for needle placement”:

- Documentation of needle placement and image interpretation
- Permanent recorded image
- Written report of ultrasound interpretation
- -26 modifier limits charges to the professional fee

AIPPS – Follow-up

Documented and Coded as E/M Services utilizing subsequent hospital care codes 99231-99233:

99231 (1.10 RVU) – patient is stable, recovering, or improving

99232 (2.06 RVU) – patient is responding inadequately to therapy or has developed a minor complication

99233 (2.96)– documentation must demonstrate the patient is unstable or has a significant new problem or complication

Must be separately documented from Anesthesiology post-operative evaluation

Quality Payment Program (QPP)

QPP established under the Medicare Access and CHIP Authorization Act (MACRA) in 2017

Two Pathways for physicians to receive adjustments to Medicare Part B professional services (negative, neutral, or positive)

1. Advanced Alternative Payment Models (APMS)
2. Merit-Based Incentive Payment System (MIPS)

University of Pittsburgh Physicians is a single multi-specialty group

Alternative Payment Model
APM

Reward Eligible Practices for Taking on Risk Related to Patient Outcomes

Three Categories

Clinical Condition, Care Episode, Patient Population

Quality Payment Program Provides a 5% incentive to Participating Practices/Clinicians who achieve thresholds

Merit-Based Incentive Payment System (MIPS)

Earn up to 100 points based on performance in 4 categories:

- Cost Performance (20 points)
- Improvement Activities Performance (15 points)
- Promoting Interoperability Performance (25 points)
- Quality Performance (40 points)

Less than 60 points – negative payment adjustment

60 points – neutral payment adjustment

Greater than 60 points – positive payment adjustment

“Required” groups or practices not participating - -9% adjustment.

Hospital Payment for Services Investment / Support

The majority of Anesthesiology departments require funding beyond third party revenue:

Averages >$200k per physician FTE

Averages (-$100,000) per physician FTE UPMC

- - - - **post CRNA expense**

Why? Low reimbursement in traditional FFS.

Required coverage for low productivity activity

Labor Epidurals Trauma Call

Cardiac Call Etc.

Summary

Continuing pressure on Anesthesia practices due to revenue constraints and increasing provider cost

Increasing “subsidies / investments / payment for services” to keep pace with provider compensation

Must demonstrated value of practices –

1. Optimization of revenue – concurrency, billing, collections
2. Quality of Care
3. Alignment and contributions to Hospital and Health System