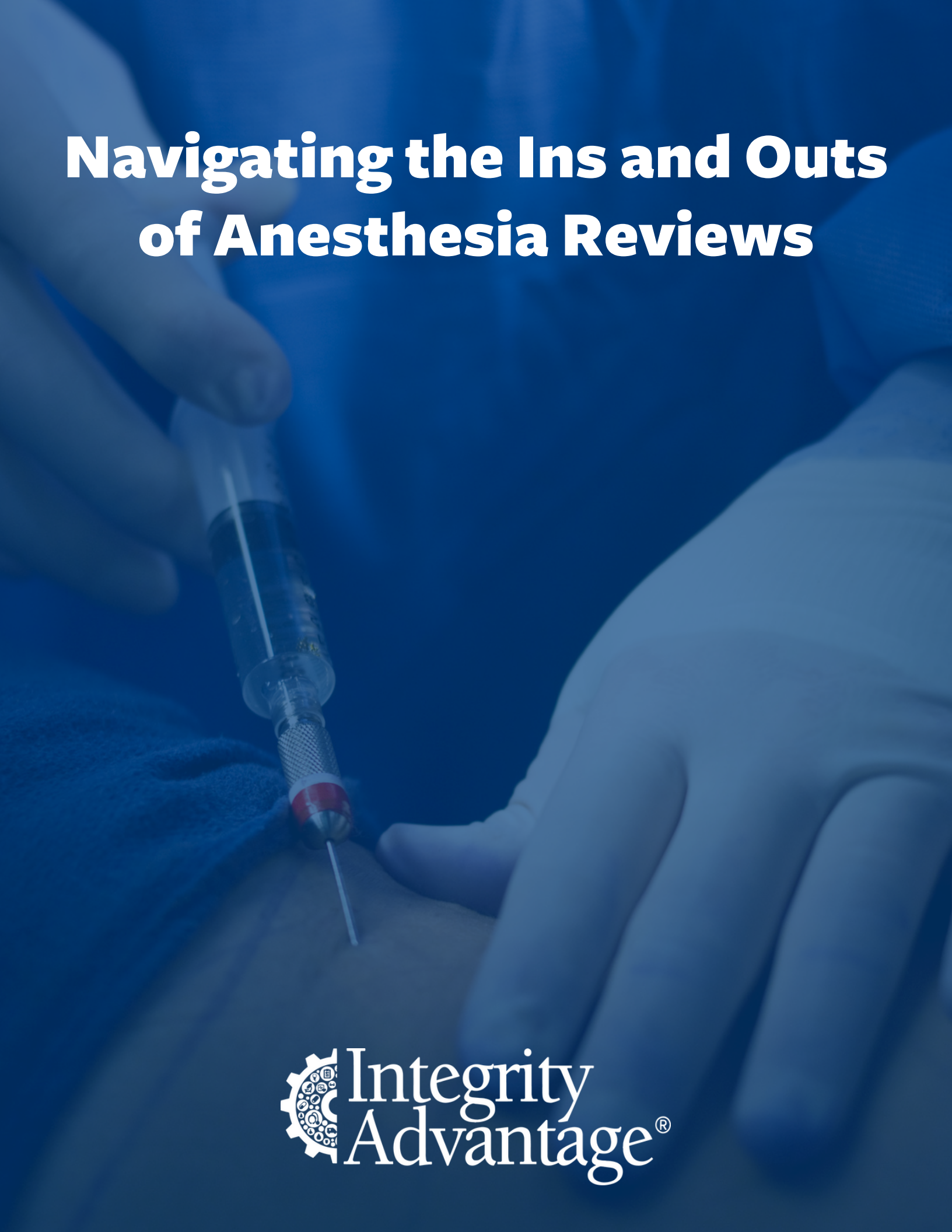
Navigating the Ins and Outs of Anesthesia Reviews



Integrity Advantage®

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Introduction

If you've been following along with the Integrity Advantage articles you know we feel strongly about the importance of medical record reviews. Essentially, these records are evidence that is critical to the case. One particular area that can be confusing (among many others) is anesthesia. Anesthesia records may appear daunting, but they do not have to be!

Anesthesia care involves the care of the patient before, during and after surgical procedures. In this article we walk you through the ins and outs of anesthesia record reviews. We start with an overview of the types of anesthesia, talk about who performs anesthesia, and share a few general guidelines to keep in mind when reviewing anesthesia claims.

What is Anesthesia?

Anesthesia is defined as, "a medical treatment that prevents patients from feeling pain during procedures like surgery, certain screening and diagnostic tests, tissue sample removal (e.g., skin biopsies), and dental work. It allows people to have procedures that lead to healthier and longer lives."

National Institute of Health education fact sheets. www.nigms.nih.gov

Anesthesia Categories

For the purposes of this article, we will focus on general anesthesia and monitored anesthesia care (MAC). However, an overview of the categories of anesthesia will help provide a frame of reference. There are five types of anesthesia, and descriptions are provided below for your reference.

Local

Applied through an injection under the skin of the surgical site to numb a small area. Local anesthesia is included in the surgical procedure. It is not separately billable. Billing both the administration of local anesthesia in addition to the surgical procedure is considered unbundling of services.

Regional (Reg)

Used to block pain around a specific area of the body without affecting the brain or breathing. Examples of this type of anesthesia are spinal, epidural, and/or nerve blocks.

General (Gen)

Administered through an IV and/or by inhalation, affecting the brain and causing unconsciousness. General anesthesia involves intubation, is easily reversible, and affects the entire body.

Monitored Anesthesia Care (MAC)

Also administered through an IV and/or by inhalation, affecting the brain and induces varying levels of mild to deep sedation, awareness, and analgesia. Patients typically do not require intubation.

Moderate (Conscious) Sedation

Similar to general anesthesia, but on a lower level, this form of anesthesia is a drug induced depressed consciousness, where the patient responds to commands, with no interventions to maintain airway or cardiovascular support required. Moderate sedation is reported with codes from the medication section of the Common Procedural Terminology (CPT) manual and are assigned based on who performs the sedation and the time of the intra-service work.

Qualified Practitioners

The anesthesia care team is made up of qualified anesthesia personnel directed by an anesthesiologist. The delivery of anesthesia is provided personally by a physician anesthesiologist or by a non-physician anesthesia practitioner directed by the physician anesthesiologist. Qualified anesthesia practitioners include:

- Physicians (MD/DO) – anesthesiologists may supervise CRNAs/AAs
- Certified Registered Nurse Anesthetists (CRNA) – may perform independently or with medical direction by MD/DO
- Anesthesia Assistants (AA) - may only perform with medical direction by MD/DO

Billing Modifiers

Anesthesia modifiers are very important. All anesthesia codes (CPT 00100-01999) require the appropriate modifier for correct reimbursement.

Provider Payment Modifiers

Pricing modifiers denote who rendered the anesthesia service which directly affects the reimbursement rate. Anesthesia services are reimbursed at three separate rates: the personally performed rate, medically directed rate, or medically supervised rate. Reimbursement rates can vary widely among plans or states, so it is critical to include the correct modifier to ensure the correct reimbursement for the service performed. Below are the appropriate pricing modifiers to use for each type of provider in specific circumstances.

Physicians

- AA – anesthesia performed personally, by an anesthesiologist (MD/DO)
- AD – anesthesia medically supervised by a physician greater than four concurrent anesthesia procedures
- QK – medical direction by a physician of two, three, or four concurrent anesthesia procedures
- QY – medical direction of one CRNA or AA by an anesthesiologist

CRNAs

- QX – CRNA with medical direction by MD/DO
- QZ – CRNA without medical direction by MD/DO

AAs

- QX – AA with medical direction by MD/DO

A CRNA may perform anesthesia services independently or with medical direction by the physician. An anesthesia assistant, on the other hand, may only provide anesthesia services under the medical direction of a physician, and thus always will require the QX modifier.

Physical Status Modifiers

Physical status modifiers are used to note the physical status of the patient at the time the anesthesia is administered. These are denoted by appending modifiers (P1-P6) to the anesthesia service. The assignment of a physical status classification is determined by the evaluating anesthesiologist. Below is a list of the physical status modifiers.

- P1 – normal health patient
- P2 – patient with mild systemic disease
- P3 – patient with severe systemic disease
- P4 – patient with severe systemic disease that is a constant threat to life
- P5 – moribund patient not expected to survive without the operation
- P6 – declared brain-dead patient whose organs are being removed for donor purposes

Billing Considerations

Most commercial payers recognize physical status modifiers and appending these to an anesthesia service may alter reimbursement. For payers that allow these modifiers, a number value is assigned to each physical status modifier. This numeric value is added to the base and time units, possibly increasing reimbursement for the anesthesia service. It is important to note that Medicare does not recognize or adjust reimbursement based on physical status modifiers.

Monitored anesthesia care (MAC) is billed slightly differently than general anesthesia services. Documentation should always clearly specify the type of anesthesia provided. As in general anesthesia, MAC services are billed using the anesthesia code that correlates to the specific surgical CPT code, along with the appropriate pricing modifiers, and the actual anesthesia time, but must also include the QS modifier to indicate it was a MAC service. If a procedure starts as a MAC service and is converted to a general anesthesia service, it must be billed as if the entire procedure was under general anesthesia. It is not appropriate to report two separate services – a general anesthesia and a MAC service. Below are the MAC service modifiers. These modifiers are appropriately used in addition to any pricing modifiers.

- QS – monitored anesthesia care (MAC)
- G8 – MAC for deep complex, complicated, or invasive surgical procedures
- G9 – MAC for patient with history of a severe cardiopulmonary condition

For example, a MAC service provided by a physician anesthesiologist, to a non-Medicare patient, with a history of severe cardiopulmonary dysfunction, is correctly billed with the modifiers AA, QS, and G9.

Time Reporting

Time is also a very important consideration that must be well documented to bill the anesthesia service correctly. Anesthesia time is defined as the period in which the anesthetist is present with the patient.

Anesthesia start time begins with patient prep for the induction of anesthesia (hooking up an electrocardiogram, pulse oximeter, securing extremities, checking IV patency, etc.). Anesthesia time ends when the practitioner is no longer providing anesthesia services (the patient is safely transferred to post-operative care). The total number of anesthesia minutes must be reported on the anesthesia service line, under the units, or line 24G on the CMS-1500 claim form. During the claims process, minutes are converted to units which are used in the payment equation to determine proper payment. In general, the longer the time, the higher the reimbursement.

Documentation Requirements

Anesthesia time is continuous from start to finish. However, blocks of time may be reported around (before and after) an interruption in anesthesia time, provided the practitioner is rendering continuous anesthesia care in the time periods around the interruption.

When reviewing anesthesia services, look for these 3 things to be included in the record:

- Documentation of the type of anesthesia given and who administered the anesthesia
- Documentation of the care provided preoperatively, intraoperatively, and postoperatively, and by whom
- Documentation of the total anesthesia time

The medical record should clearly identify the type of anesthesia administered, the care provided and the exact minutes of anesthesia care to support the code billed. Documentation should include the preoperative evaluation.

If multiple surgical procedures are performed during a single anesthesia administration, the anesthesia code representing the most complex surgical procedure is to be reported. The time reported is the combined total for all procedures.

When reviewing anesthesia claims, there are 3 important questions to consider:

1. Was the correct anesthesia code applied for the surgical procedure performed?
2. Were the appropriate payment modifiers appended?
3. Were the correct units reported on the claim?

If the answers to any of the above questions are no, then the service was not billed appropriately, and improper payment may have been made to the provider.

Anesthesia services can be intricate and complex but reviewing anesthesia claims does not have to be. Keep these considerations in mind when reviewing anesthesia claims to streamline your review and focus on the required documentation items that determine if the anesthesia code was billed appropriately or not.

No open anesthesia cases?

Let's use the information provided to mine your data:

- Query your data for anesthesia and surgical services billed for the same member, on the same date of service. Review for the same provider (should be caught by an edit, but let's not assume) and review for different rendering and/or billing providers.

- Query your data for monitored anesthesia care (MAC) and general anesthesia, for the same member, same date of service. Again, assuming your edits didn't catch it, review for the same provider and review for different rendering and/or billing providers.

- As with any timed codes, run analysis to detect providers that may be billing for improbable days. Consider the modifiers and who is rendering the service, not only who is billing the services. Also consider your membership and market penetration.