New Provider and Reappointment Training

Anesthesiology Coding

March 2017
Course Objectives

- Review basic principles of coding and documentation of anesthesia services
- Review resident/fellow supervision and documentation requirements for Medicare, Medicaid, and TRICARE
- Review data replication and scribe policies
Principles of Coding and Documentation

Appropriate billing requires three components:

- Doing only what is medically necessary
- Documenting what is done
- Billing what is documented

Understanding and applying coding and documentation conventions allows for compliant billing, potential for increased revenue, and generally improved quality of the medical record documentation.
Compliance is Essential to Proper Reimbursement

Appropriate documentation and billing practices make for good patient care and maximized compensation.

**Federal Oversight:**

- **Recovery Audit Contractors (RACS)**—Medicare, Medicaid and commercial insurers pay third party contractors to recoup inappropriately documented or billed services

- **Office of Inspector General (OIG), Health & Human Services**—works with the Department of Justice to investigate suspected abuse or fraudulent claims

- Routine error rate testing and auditing programs
Coding and Documenting Anesthesia Services
Reimbursement of Anesthesia Services

- Basic value
  - 
- Time units
  - 
- Physical status modifier
  - 
- Any qualifying circumstances
  - 
- Any additional modifiers for unusual procedures or services
Basic Value

A basic value is listed for anesthetic management of most surgical procedures.

- The base unit includes:
  - pre and post anesthesia care
  - administration of fluids and/or blood products incident to anesthesia care
  - interpretation of non-invasive monitoring

- The base unit does not include:
  - placement of arterial, central venous, and pulmonary artery catheters
  - use of transesophageal echocardiography (TEE)
Measuring Time

- Anesthesia time is defined as the period during which an anesthesia practitioner is present with the patient.

- Time **starts** when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room or an equivalent area and **ends** when the anesthesia practitioner is no longer furnishing anesthesia services to the patient, that is, when the patient may be placed safely under postoperative care.

- Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service.

- 1 unit = 15 minutes
Physical Status Modifiers

All anesthesia services are reported using one of the following modifiers:

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

Example: 00100-P1 – Anesthesia for procedures on salivary glands, including biopsy – normal healthy patient
Qualifying Circumstances

In addition to the procedure code, extraordinary conditions, unusual risk factors, or notable conditions may be billed, if applicable. More than one qualifying circumstance may be selected.

+99100  Anesthesia for patient of extreme age, younger than 1 year and older than 70
+99116  Anesthesia complicated by utilization of total body hypothermia
+99135  Anesthesia complicated by utilization of controlled hypotension
+99140  Anesthesia complicated by emergency conditions (specify)

An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part.
Critical Care Services

- Critical care is the direct delivery by a physician of medical care for a critically ill patient.

- A critical illness acutely impairs one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration.

- Critical care involves high complexity decision making to assess, manipulate, and support vital system functions to treat single or multi-system failure.
The following are key phrases which help substantiate critical care services:

- *Impairs one or more vital organ system(s)*
- *High probability of deterioration*
- *High complexity decision making*
- *Assess, manipulate, and support vital system function(s)*
- *Treat organ system failure*
- *Prevent further deterioration*
Additional Modifiers for Unusual Procedures or Services

Modifier 23 – Unusual Anesthesia

- Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding modifier 23 to the procedure code of the basic service.
Modifiers That Impact Payment

Modifier 22 – Increased Procedural Services

- When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). Note: This modifier should not be appended to an E/M service.

Modifier 53 – Discontinued Procedure

- Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the individual for the discontinued procedure. Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite.
Modifiers Approved for Ambulatory Surgical Centers

Modifier 73 – Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia

- Under these circumstances, the intended service that is prepared for but cancelled can be reported by its usual procedure number and the addition of modifier 73. Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported.

Modifier 74 – Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia

- Under these circumstances, the procedure started but terminated can be reported by its usual procedure number and the addition of modifier 74. Note: The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported.
Anesthesia Global Package

Medical and Surgical Procedures Included in the Global Package

- General anesthesia, regional anesthesia, and MAC services are considered a global package of services, and include the following:
  - The usual preoperative and postoperative visits
  - Anesthesia services during the procedure
  - Administration of intravenous fluids including blood and/or blood products
  - Intra-operative laboratory evaluations
  - The usual monitoring services [such as electrocardiogram (ECG), temperature, blood pressure, pulse oximetry, capnography, infrared end-tidal gas analysis, mass spectrography, bispectral electroencephalography, and transcranial Doppler] and their interpretation
Anesthesia Global Package

Medical and Surgical Procedures Not Included in the Global Package

- The following forms of monitoring are not included in the global package:
  - Pulmonary artery catheter insertion
  - Central venous catheter insertion
  - Intra-arterial catheter insertion
  - Nerve blocks for postoperative pain relief (single injections and continuous catheters, including epidural, spinal, and peripheral nerve blockade)
  - Ultrasound-guided central venous access and assisted peripheral nerve blockade
  - Transesophageal echocardiography (TEE) monitoring and interpretation
Teaching Physician Guidelines
Medicare Teaching Physician Reimbursement

- Medicare pays for Resident Physician services through Medicare Part A to the hospital. Medicare makes the payments based on the proportionate share of Medicare patients seen at the teaching hospital.

- Teaching Physicians (TPs) are paid by Medicare Part B on a fee-for-service basis.

- Medicare Part B will pay for TP services with the Resident Physician when the teaching physician participates and documents his/her involvement in the service. If the TP does not participate in a given patient service when a resident is involved, and meet specific documentation requirements, the TP may not bill for the service.
Medicare Teaching Physician Requirements

- The Teaching Anesthesiologist must document in the medical record that he/she was present during all critical (or key) portions of the procedure.

- The Teaching Anesthesiologist’s physical presence during only the preoperative or postoperative visit with the patient is not sufficient.

- When the Teaching Anesthesiologist is involved in two concurrent anesthesia cases with Residents, he/she may bill the usual base units and anesthesia time for the amount of time he/she is present with the Resident.

  - The Teaching Anesthesiologist must be present and document that they were present for the key/critical portions of the anesthesia service or procedure.

  - Must be immediately available to furnish anesthesia services during the entire procedure or have another teaching anesthesiologist within same group that can be immediately available to the Resident.
Critical Care Time

- A combination of the Teaching Physician’s (TPs) documentation and the Resident’s documentation may support the critical care service. The TP must be present the entire time in order to bill.

- The medical record documentation of the TP must provide the following information:
  - Time the TP spent providing critical care,
  - The patient was critically ill during the time the TP saw the patient,
  - What made the patient critically ill; and
  - Nature of the treatment and management provided by the TP. The medical review criteria are the same for the TP as well as for all physicians.

Acceptable Attestation:
“Patient is in critical condition with ______. I spent ___ minutes providing critical care services of ______. I reviewed the Resident's documentation and I agree with the Resident's assessment and plan of care.”
Medical Direction of Anesthesia Services

- Medicare coverage of medical direction of anesthetists requires the billing physician to:
  - Perform a pre-anesthetic examination and evaluation
  - Prescribe the anesthesia plan
  - Participate personally in the most demanding procedures in the plan including induction and emergence
  - Ensure that the anesthetist performs the anesthesia plan
  - Monitor the course of the administration at intervals
  - Remain in the operating suite for the entirety and available to return if needed
  - Provide indicated post-anesthesia care
Medical Direction – Documentation Requirements

Medicare requires the billing physician to document the following:

- Performance of pre-anesthesia exam and evaluation
- Provision of indicated post-anesthesia care
- Presence during some portion of the anesthesia monitoring
- Presence during the most demanding procedures including induction and emergence
Medical Direction – Concurrent Procedures

Medical direction of two, three or four concurrent procedures

- Physician services are not payable by Medicare or Medicaid if the billing physician:
  - leaves the immediate area of the operating suite for more than a short duration;
  - devotes extensive time to an emergency case; or
  - is otherwise not available to respond to the immediate needs of the patient

Supervision of more than four concurrent procedures

- Reimbursed at a supervision rather than medical direction rate
- Requires pre-anesthesia exam and determination of the anesthetic agent
- If the billing physician is present at induction, reimbursement increase
North Carolina Medicaid Teaching Physician Requirements

- The teaching anesthesiologist must document in the medical records that s/he was present during all critical (or key) portions of the procedure. The teaching anesthesiologist’s physical presence during only the preoperative or postoperative visits with the beneficiary is not sufficient to receive payment.

- In those cases in which the teaching anesthesiologist is involved in two concurrent anesthesia cases with residents, the teaching anesthesiologist may bill the usual base units and anesthesia time for the amount of time s/he is present with the resident.

- The teaching anesthesiologist must document his or her involvement in cases with residents.

Acceptable Attestation for NC Medicaid:

“I discussed the patient with the Resident and agree with the assessment and plan as documented.”
TRICARE Teaching Physician Requirements

- The TP must demonstrate and render sufficient personal and identifiable medical services to the patient to exercise full, personal control over the management of the case.

The TRICARE Manual states the TP must:

- Review the patient’s history and the record of examinations and tests in the institution, and make frequent reviews of the patient’s progress;

- **Personally examine the patient**;

- Confirm or revise the diagnosis and determine the course of treatment to be followed; and

- *Either* perform the physician’s services required by the patient or supervise the treatment so as to assure that appropriate services are provided by physicians in training and that the care meets proper quality level; and

- Be present and ready to perform any service performed by an attending physician in a nonteaching setting when a major surgical procedure or a complex or dangerous medical procedure is performed; and

- Be personally responsible for the patient’s care, at least throughout the period of hospitalization.
TRICARE Teaching Physician Requirements

The responsibilities of a supervisory attending physician are demonstrated by such actions as:

- Reviewing the patient’s history and physical examination;
- Personally examining the patient within a reasonable period after admission; and
- Confirming or revising the diagnosis;
- Assuring that any supervision needed by the physicians in training was furnished; and
- Making frequent reviews of the patient’s progress.

Simply reviewing a patient’s progress note and not being available when a resident physician in training renders care is not billable to TRICARE. The TP must document his/her presence as also required by Medicare.

Acceptable Attestation for TRICARE:
“"I have seen and evaluated the patient and reviewed the patient’s history, examination and progress. I agree with the assessment, diagnosis and plan of the Resident as documented."
Medical Students

- A medical student has no qualifications for providing billable medical care to a patient. They are not Residents.

- Per CMS Policy:
  - The only medical student documentation that may be referenced by a Resident or TP is the Review of Systems (ROS) and/or Past, Family and Social history (PFSH).
  - Any contribution and participation of a medical student to the performance of a billable service (outside the collection of the system review and history) must be performed in the physical presence of a TP or a Resident.
  - The Teaching Physician or Resident must verify and re-document the history of present illness, perform and re-document the physical exam and medical decision making.
  - Written documentation in the medical record for Medicaid patients must clearly designate the supervising physician and be signed by that physician.

Note: If a medical student is serving as a scribe, then all requirements for a scribe must be met. See UNC Health System Policy: SYS014
Shared Visits with an APP
Documentation Requirements for Shared Visits

- The following APPs are eligible to bill for shared visits within their scope of practice:
  - Nurse Practitioners; Physician Assistants; Certified Nurse Specialists; and Certified Nurse Midwives

- APPs must be from the same group practice as the physician.

- Both the physician and the APP must each personally perform a substantive portion (at least ONE of the three key components: History, Examination, or Medical Decision Making) of an Evaluation and Management (E/M) visit face-to-face with the same patient on the same date of service.

- It is NOT a shared visit if the physician participates in the service but does not perform and document the face-to-face encounter.

- It must be medically necessary for both the physician and the APP to see the patient on the same day.
Documentation Requirements for Shared Visits

- Providers may utilize the .att statement (SmartPhrase) in Epic notating: “It was medically necessary for me to see the patient because ***. My visit included ***.”

- The medical record should link the APP and the physician notes.

- A physician co-signature alone or statement, such as, “Agree with the above” is not sufficient.
Place of Service Guidelines for Shared Visits

Shared visits apply to the following settings:

- Hospital inpatient
- Hospital outpatient
- Emergency Department

Shared visits cannot be billed in a physician-based clinic (POS 11) or while providing critical care.

- When a split/shared visit between an APP and a physician occurs in the office or clinic setting (not hospital-based), the service may be considered to be performed “incident-to”, if the incident-to requirements are met.
Documentation Integrity in Electronic Health Records
Data Replication in Electronic Documentation

- Altering notes improperly may undermine the integrity of the electronic health record (EHR) and jeopardize reimbursement and patient safety.
  - Medicare does allow documentation changes within limits, including amendments, corrections, addenda, and delayed entries if they are clearly identified and there is no tampering with original content.
- The billing provider is responsible for the entire content of the documentation including its accuracy and any copied information.
- Clinical documentation must demonstrate clearly distinct variation between notes.
- The HPI, ROS, exam, and impression and plan must demonstrate documentation relevant to EACH clinical encounter and be reviewed and edited appropriately.
- When possible, the use of copying and pasting of laboratory, pathology or radiology results in its entirety should be minimized in order to reduce “note bloat”. Summarizing findings and medical judgment is encouraged. See Policy SYS 011 Copying and Pasting and Data Replication in Electronic Documentation.
Software Features and Capabilities

Templates

- Auto-populating tools and drop down menus may multiply the effect of an incorrect piece of data and may also contribute to the inappropriate up coding of an encounter.

Cloning

- Cloning occurs when an entry in the EHR is worded the exact same way or is very similar to previous entries.
- When entries are copied and pasted without being edited, medical necessity is not established because the documentation isn’t specific to the current patient encounter.
- Patient care could be compromised if old treatment plans are copied and pasted.
“Make Me the Author” Function in Epic

- Allows a provider to substitute their signature for that of another person who entered notes in the EHR.

- This function does not replace the attestation requirement for a Teaching Physician working with a Resident physician as it does not support the documentation by the Teaching Physician of their face-to-face involvement with the patient during the patient encounter.
Tips to Avoid Re-entering Documentation

For physical exams performed that were identical in scope and findings, make a statement in the current note.

- “Same exam performed as on 11/15/16 with same findings as below.”

You may refer to material reviewed in EPIC instead of entering specific detail into the note.

- “Medication list and medical history reviewed.”
- “Patient intake form dated November 15, 2016 reviewed; all systems other than those in HPI are negative.”
Use of Scribes

Scribes MAY NOT:

- Provide any clinical care to patients
- Interject their own observations, impressions or recommendations of care for care into the EMR
- Enter medication orders on behalf of providers

Scribe Documentation: If the encounter note was written by a scribe, the scribe must sign the note and indicate that they were acting as a scribe. For example: “Written by xx, (title), acting as scribe for Dr. Z.”

Provider Documentation: The provider should include a statement that they reviewed the documentation, and attest to the accuracy of the note. The provider may add to the note if additional information is needed. The provider then co-signs the note. See Policy ADMIN 0268/SYS 014 Documentation of Care Health Related Data by Scribes.
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