The Basics of Anesthesia Billing

Paul W. Santoro CRNA, MS

November 5, 2011

Oregon Association of Nurse Anesthetists
Medicare

Anesthesia billing and reimbursement starts with a review of the Medicare reimbursement rules, since most other payers use similar methodology.
Anesthesia Reimbursement has long been an exception compared to other medical and surgical billing. Resource Based Relative Value Scale (RBRVS) vs. Relative Value Guide (RVG)

The reason for the difference? RBRVS pays per Procedure, RVG takes into account the "Time factor" in anesthesia delivery.
Medicare Reimbursement

Two Resourced-Based Components:

- Base Value (or Base Units) Assigns a numeric unit value (Base Value) for each surgical procedure based on Surgical CPT code
- Time Value (or Time Units) expressed in 15 minute increments
Relationship between CPT Code and Base Units

- Number of Surgical CPT Codes = $\sim 5000$
- Number of Anesthesia CPT Codes = $\sim 300$
- Most Anesthesia Codes can be crosswalked to multiple surgical codes, some over 200
Base Value (Units)

Considers:

- Anesthesia Risk
- Anticipated Surgical Problems
- Skill Level Required
- General “Time” Required
Time Units

- Calculated using “Anesthesia” Start and Stop Times
- “Constant Attendance”
- Medicare defines one unit of time as a 15 minute increment (does not round units)
- Calculated by dividing anesthesia time by 15 minutes, rounded to one decimal place
- Some Commercial payers define time in 10 or 12 minute units (or may negotiate time unit)
- Medicare pays the same anesthesia “Conversion Factor” for both base and time units
Discontinuous Time

Can add blocks of time around an interruption in anesthesia time as long as continuous anesthesia care ("Constant Attendance") is delivered within the time periods around the interruption.
Concurrency

The rules to keep in mind:

- A CRNA can only be in one place at one time.
- An Anesthesiologist can only be in four places at one time (if billing medical direction).
- Make sure there is one minute between cases.
- Use one clock. Forget about matching OR times!
- With electronic submission these discrepancies are ALWAYS detected and slow reimbursement.
Concurrency

Medicare does allow an Anesthesiologist to perform some other tasks during Medical Direction:

- Address an emergency of short duration
- Administer an epidural to laboring patient
- Perform periodic monitoring of an OB patient
- Receive patients entering suite for the next surgery
- Check on or discharge patients in the PACU
- Coordinate scheduling matters
Total Payment

Total Payment ($) = Conversion Factor ($) \times (\text{Sum total of Base units} + \text{Time units})
Payment Example

- Procedure: Ventral Hernia Repair (00832)
- Base Units: 6
- Anesthesia Time: 6
- Conversion Factor: $22.67
- Total Payment: $22.67 * (6 + 6) = $272.04
Anesthesia Claims Modifiers

**Anesthesiologist**

- **AA** – Personally Performed by an Anesthesiologist
- **QK** – Medical Direction of two, three or four concurrent procedures involving qualified individuals
- **AD** – Medical Supervision by a physician; more than four concurrent procedures
- **QY** – Medical Direction of one CRNA by an anesthesiologist
### Anesthesia Claims Modifiers

- **QX** – CRNA with medical direction by a physician
- **QZ** – CRNA without medical direction by a physician
Anesthesia Claims Modifiers

Add-ons

- **QS** – Monitored Anesthesia Care Services
- **59** – Distinct Procedural Service (indicates a service was independent from other services performed on the same day)
- **53** – Discontinued Procedure (Cancelled Case after the induction of anesthesia)
- **Q6** – Locums Coverage (anesthesiologist only)
Medicare’s 7 Physician Rules for Medical Direction

1. Perform pre-anesthetic exam and evaluation
2. Prescribe the anesthetic plan
3. Personally participate in the most demanding aspects of the anesthetic, including if applicable induction and emergence
4. Ensure that delegated aspects of the anesthetic are performed by a qualified individual
Medicare’s 7 Physician Rules for Medical Direction

5. Monitor the course of the anesthetic at frequent intervals

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

7. Provide indicated post-anesthetic care
Medicare’s 7 Physician Rules for Medical Direction

These 7 steps must be documented in the medical record as a condition of payment.

These are Medicare requirements for payment under Medical Direction, not Standards of Care.
Medical Direction Payment

- Anesthesiologist: QK
- CRNA: QX
- 50:50 split between Anesthesiologist and CRNA
- Anesthesiologist can cover up to four concurrent cases (capturing 50% payment for each case)
- Must meet (and document) the 7 Medical Direction Conditions of Payment Rules
Medical Supervision Payment

- Anesthesiologist covering beyond four concurrent cases
- Anesthesiologist: AD
- CRNA: QX
- 50% of total available payment to CRNA (as in Medical Direction)
- Anesthesiologist paid 3 base units, plus an additional unit if they participate (and document) in Induction
Personally Performed Payment

- Anesthesiologist: AA
- CRNA: QZ
- Both Providers: 100% of available payment
Blocks: are they billable as a separate service?

- Basic Question: Are they for the operative Anesthetic or Post-operative Pain Control?
- Block with MAC or a General Anesthetic during the operative case?
- Document in the record “for post-operative pain”
- Make sure your billers understand and will look for the added documentation
Procedures and Procedure Codes

- Secondary Code: 59
- Invasive Monitoring
- Pain Management
- Emergency Intubation

Medicare uses “non-anesthesia” CTP codes, used by all providers

Payment based on the physician RBRVS fee schedule

“Flat Fee” without allowance for actual time
Physician Quality Reporting Initiative (PQRI)

- Started in late 2007
- Initially 74 Measures across all specialties
- Must report measures on ≥ 80% of Claims with applicable Surgical CPT codes
- Currently about Reporting not Achieving
- Current Anesthesia Measure: (#30) Timely Administration of Antibiotic Prophylaxis
- Eligible for 1.5% Medicare Bonus
Physician Quality Reporting Initiative (PQRI)

Other Proposed Anesthesia Measures:
- Prevention of Catheter-Related Bloodstream Infections
- Prevention of Ventilator-Associated Pneumonia
- Perioperative Temperature Measurement for Surgical Patients Under General Anesthesia
- Stress Ulcer Disease Prophylaxis in Ventilated Patients
Other Payers

- Most Commercial Payers follow the Medicare Reimbursement Rules to one degree or another
- Understand the differences so you will be aware of any special billing requirements
- Know the Conversion Factors
- CRNA Payment (Split, Procedures, etc)
The Simple Things To Do

- EDUCATE your Providers
  - What is billable and how to document it

- EDUCATE your Billers
  - What to look for on the record and where it will be documented (lines, post-op blocks, discontinuous time, procedures)

- Develop a good “Front-End” Process
  - Records Management, Submissions
  - Anesthesia Records Review
The Simple Things To Do

- Avoid Concurrency Problems
- Capture Discontinuous Time
- Capture "Post-Op" Pain Blocks
- Capture Procedures (Lines, Intubation)
- Locums Billing
- Set Charge Rate high enough to capture outliers
Not So Simple Things To Do

- Secure “good” Commercial Contracts
- Accurate Coding and Billing
- Back-End work (Collections)
- Effect Operating Efficiency
Questions To Ask

- Billing: Done In-House or Outsourced?
- Done by Certified Coder?
- Do we have relevant and accurate Management Reports?
  - Financial Performance
  - Receivables
  - Efficiency Data
  - Benchmarking
- Is someone looking at them?
## Medical vs. Coding Terminology

Be Specific.....

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Coding</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thoracotomy/Thoracoscopy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(00540) not specified</td>
<td></td>
<td>12 BU</td>
</tr>
<tr>
<td>(00541) utilizing one lung ventilation</td>
<td></td>
<td>15 BU</td>
</tr>
<tr>
<td>Knee Arthroscopy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>diagnostic</td>
<td></td>
<td>3 BU</td>
</tr>
<tr>
<td>surgical</td>
<td></td>
<td>4 BU</td>
</tr>
<tr>
<td>Shoulder Arthroscopy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>diagnostic</td>
<td></td>
<td>4 BU</td>
</tr>
<tr>
<td>surgical</td>
<td></td>
<td>5 BU</td>
</tr>
</tbody>
</table>
Medical vs. Coding Terminology
Be Specific…..

- CABG/Mitral Valve Procedures
  - (00562) with pump oxygenator  20 BU
  - (00566) without pump oxygenator  25 BU

- Craniotomy
  - (00210) Intracranial Procedure, not specified  11 BU
  - (00218) Intracranial Procedure, sitting position  13 BU
Factors Affecting Department (Group) Financial Performance

- Practice Setting (Location, Specialties, Coverage requirements)
- Volume
- Operating Room Efficiency
- Case Mix
- Payer-Mix
- Practice Model
- Revenue-Cycle
Billing Financial Metrics

Understand the difference between Gross Charges, Reimbursement Rate and Net Revenue

- Often these three numbers are used interchangeably by administrators
- Charges (Gross Charges): Unit Rate set by the Practice
- Reimbursement Rate: Unit Rate Payer will pay you
- Net Revenue: Actual Money Collected
- Contractual Write Off: Difference between Gross Charge and contracted Reimbursement Rate
Billing Financial Metrics

- **Gross Charges**
  - Procedure: Ventral Hernia Repair (00832)
  - Base Units: 6
  - Anesthesia Time: 6
  - Charge Rate: $72.00
  - Total Charge: $72.00 * (6 + 6) = $864.00

- **Reimbursement**
  - Procedure: Ventral Hernia Repair (00832)
  - Base Units: 6
  - Anesthesia Time: 6
  - Medicare Reimbursement Rate: $22.67
  - Total Payment: $22.67 * (6 + 6) = $272.04

**Contractual Write Off** = $591.96
Billing Financial Metrics

Should be tracked and reviewed monthly in order to detect early warning signs of problems

- Overall Accounts Receivable (A/R)
- Gross Collections Ratio
- A/R Aging Breakdown
- Net Collection Rate
Overall Accounts Receivable (A/R)

Describes Outstanding Gross Charges

- Relevant for Trending Practice Activity
- New Trends warrant further investigation
  - Case Volume Fluctuations
  - Collection Problems
  - Charge Rate Adjustment
Gross Collections Ratio

Describes Net Collections as a Percentage of Gross Charges

\[
\text{Net Collections} \times \frac{100}{\text{Gross Charges}}
\]

- Varies from practice to practice based on Unit charge Rate and Payer-Mix
- New trends: Payor-Mix changes, “Back-end” Collection changes
- Useful in predicting future cash
- Anesthesia Benchmark:
  - Mean: 44.7%
  - 75th Percentile: 38.3%

(MGMA 2007 Cost Survey for Anesthesia Report)
A/R Aging Breakdown

Calculates the percentage of total A/R in certain aging categories

- Measures how quickly the practice collects (or resolves) Charges
- Important indicator of billing and collection performance
- Early warning signs of “new” collection problems
- Categories useful to assess: <30 days, 31 - 60 days, 61 - 90 days, 91 – 120 days and >120 days.
A/R Aging Breakdown

Anesthesia Benchmarks:

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Mean</th>
<th>75&lt;sup&gt;th&lt;/sup&gt; Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;30 days</td>
<td>53.5%</td>
<td>46.4%</td>
</tr>
<tr>
<td>31 - 60 days</td>
<td>18.4%</td>
<td>13.3%</td>
</tr>
<tr>
<td>61 - 90 days</td>
<td>8.4%</td>
<td>7.2%</td>
</tr>
<tr>
<td>90 – 120 days</td>
<td>5.2%</td>
<td>4.2%</td>
</tr>
<tr>
<td>&gt;120 days</td>
<td>14.5%</td>
<td>8.35%</td>
</tr>
</tbody>
</table>

(MGMA 2007 Cost Survey for Anesthesia Report)
Resources

- Medicare: [www.cms.hhs.gov](http://www.cms.hhs.gov)
- AANA: [www.aana.com](http://www.aana.com)
- ASA: [www.asahq.org](http://www.asahq.org)
- Anesthesia Staffing Consultants: [www.ASConsultants.com](http://www.ASConsultants.com)
- Anesthesia Answer Book: [www.decisionhealth.com](http://www.decisionhealth.com)
- Study Guide for Anesthesia Coding Certification: [www.medicalspecialitycoding.com](http://www.medicalspecialitycoding.com)
- Jim Scarsella: jscarsella@asconsultants.com