



National Alliance of Medical Auditing Specialists (NAMAS)

Auditing Pain Management & Anesthesia

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About Your Faculty

- BS Health Science- SUNY Cortland (1995)
- Consultant, Doctors Management, LLC
 - 2013 -present
- President- Modern Conventions in Compliance, Inc.
 - 2004-2012
- Senior Consultant- Medical Management Institute
 - 1995-2003
 - CPC (2000), CPC-I (2004), CEMC (2009), CPMA (2013)
 - AHIMA Approved ICD-10 Ambassador/Trainer (2013)



What's The Big Deal?

- In 2007 alone, Medicare paid more than \$2 billion for interventional pain management including:
 - Nerve blocks
 - Spinal cord stimulation (neurostimulation)
 - Joint injections (with and without guidance)
 - Trigger point injections
- Considerations:
 - POS errors (e.g. -11 vs. -22)
 - Modifier -50 and lateral considerations (e.g., -RT / -LT)
 - E&M is NOT separately reportable unless "significant and separately identifiable" (e.g., modifier -25)
 - Fluoroscopy/CT guidance "bundled w/ many procedures
 - CPT code 27096 (Sacroiliac joint injection "with image guidance"

Learn From The Past...

- DOJ reported that a provider was convicted on 56 counts of mail, wire and healthcare fraud when he billed for more than 100 patients per day while claiming “complex epidurals and nerve blocks when in fact he performed trigger point injections”
- A Maryland anesthesiologist pleaded guilty to healthcare fraud claiming “moderate office visits” (e.g., 99214) without adequate documentation to support the levels of service reported.
- An audit of an AL pain clinic by AdvanceMed, a Zone Program Integrity Contractor (ZPIC), has been ongoing since January 2013. Officials with the pain clinic were informed late last month that AdvanceMed would continue the audit and stop all Medicare payments to the facility during the review. The clinic has announced it may need to close its doors.

Pain & Anesthesia Landscape

- CERT- high error rates with injections / injectables
- RACs have placed additional scrutiny on pain management and anesthesia services (e.g., medical direction and post op pain epidurals)
- Audits are more focused on MDM than ever. Procedures repeated at frequent intervals without documentation of significant relief may be challenged
- Modifier-59 is “last resort” modifier and should not be reported when other modifiers are applicable (e.g., -50, -51, -RT, -LT, etc.)
- Pain management (specialty code 72) - 56% error rate identified in 2008 OIG medical review
- Always consider CPT codes that include fluoroscopy and or needle guidance

CPT 2014: Changes Impact Pain Mgt

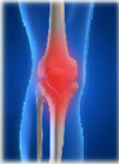
- **Chemodenervation:**
 - New CPT codes added in 2014 for muscles of neck and larynx
 - **64616** Chemodenervation of muscles; neck muscles excluding larynx, unilateral
 - For bilateral procedures, report modifier -50
 - For needle EMG guidance or muscle electric stimulation, report +95873 or +95874
 - **64617** Chemodenervation of muscles; larynx, unilateral, percutaneous
 - For bilateral procedures, report modifier -50
 - Do NOT report with 95873 or 95874
 - Report chemodenervation agent separately (e.g., J0585)

CPT 2014: Changes Impact Pain Mgt

- **Chemodenervation:**
 - 6 new CPT codes added in 2014 for chemodenervation of extremities/trunk muscles
 - (report chemodenervation agent separately (e.g., botulinum) HCPCS II code J0585)
 - **64642** Chemodenervation of one extremity; 1-4 muscles
 - **+64643** each additional extremity, 1-4 muscles
 - **64644** Chemodenervation of one extremity; 5+ muscles
 - **+64645** each additional extremity, 5+ muscles
 - **64646** Chemodenervation of trunk muscles; 1-5 muscles
 - **+64647** 6+ muscles
- ✓ Report once per extremity; codes 64642-64645 are reported up to 4 total units when all 4 extremities are injected
- ✓ 95873 or 95874 for guidance; modifier -50 does not apply

Auditing Considerations

- **Joints and Bursa**
 - 20600-20610 (unilateral procedures)
 - Small, intermediate, large joints
 - Injection or aspiration
 - Specify substance and dose
 - 77002/77012 for fluoroscopic/CT needle guidance
 - Modifier -50 versus modifiers LT/RT
 - ICD-10 consideration, document laterality
- **Tendons, Ligaments, Muscles**
 - Trigger point injections (CPT codes 20550-20553)
 - SIJ (without fluoroscopy or CT guidance), report 20552




True or False?

When auditing anesthesia services, the auditor must confirm that all ASA codes related to all surgical services under a single anesthetic administration are listed from highest base value to lowest base value.

True
Incorrect

False
Correct



Reset Questions

Auditing Anesthesia

- PS / ASA considerations
- Multiple procedures under single anesthesia case
- Modifiers
- NCCI reminders
- Separately billables
- Medical direction / concurrency
- Add-on codes
 - There are no 2014 CPT changes to the Anesthesia chapter



Auditing Anesthesia Services

- Reporting anesthesia services presents a very unique set of factors in terms of code selection
 - Base units (ASA)
 - Time units (typically 15 minute increments)
 - Concurrency (more than 1 case)
 - Medical Direction (CRNAs)
 - Separately reportable services
 - CPT Modifiers
 - 23 (unusual anesthesia) and 47 (Anesthesia by the surgeon)
 - Multiple/separate procedures
 - Select the "most complex" only
 - Topical, local, regional (blocks/epidurals), MAC, General
- Time unit + Base unit + Modifying Units * C.F. = Allowed Amount



What's Included in Anesthesia

- General/regional anesthesia
- Pre-op and post-op visit
- Administration of fluids
- Usual monitoring (ECG/EKG, temperature, pulse oximetry, BP, capnography)
- Bundled services included:
 - Laryngoscopy (315xx), bronchoscopy (316xx), introduction of needles/catheters (36000-36015), venipuncture, otorhinolaryngologic services, CPR, temporary pacing, cardioversion, interp of labs, intubation (gastric)

Physical Status and Qualifying Circumstances (Non-Medicare)

- Read question carefully to determine if a physical status modifier (P1-P6) is appropriate
 - P1 - normal healthy patient
 - P2 - mild systemic disease
 - P3 - severe systemic disease
 - P4 - severe...constant threat to life
 - P5 - moribund pt. not expected to survive w/o surgery
 - P6 - brain-dead patient with donor organs
- Be aware of the qualifying circumstance codes
 - +99100 - extreme age (>70yrs or <1yr)
 - +99116 - use of total body hypothermia
 - +99135 - use of controlled hypotension
 - +99140 - emergency services

HCPSC II Anesthesia Modifiers

- AA- Personally performed by anesthesiologist
- QK- Medical direction of 2, 3, 4 concurrent cases (MD claim)
- QX- CRNA service with medical direction (CRNA claim)
- QY- Medical direction of one CRNA (MD claim)
- QZ- CRNA service without medical direction
- AD- *Supervision* of more than 4 concurrent cases (3 base allowed)
- QS- Monitored Anesthesia Care (MAC)
- G8- monitored anesthesia care for deep complex, complicated, or markedly invasive surgical procedure.
- G9- monitored anesthesia care for patient who has history of severe cardiopulmonary condition
 - Medical direction requires that the Anesthesiologist is present at induction, emergence, monitor at "frequent" intervals, and be available throughout the entire case



Steps To Properly Select Codes

- Select proper surgical code (CPT)
 - If multiple surgeries, consider only highest base value
- Crosswalk the surgery code to the ASA code (RVG)
- Determine number of base units (RVG)
- Determine the proper number of time units (reporting varies)
- Determine proper modifiers (anesthesia type and providers)
 - May require -QS for MAC, -QK/-QX for medical direction, etc.)
- Assign accurate physical status modifier (if applicable)
- Apply any applicable qualifying circumstances (e.g., emergency)
- Determine if any separately billable procedures are documented
 - Includes A-lines, CVP, epidurals for post-op pain (requested by surgeon)
- Determine total units for anesthesia reporting

Performing Anesthesia Audits

- I. Getting prepared:
 - Gather necessary resources such as: CPT, RVG, ICD-9, access to payer fee schedules and coverage determinations, etc...
- II. Determining sample size
 - 10-40 cases per provider (current)
 - Get good mix (e.g., personally performed, medically directed, etc.)
 - Prospective versus retrospective (opinions vary)
- III. Selecting cases and acquiring records
 - Get everything you need to include the pre-anesthesia evaluation and plan, anesthesia record, post-anesthesia plan, billing history (if applicable), Remittance Advice, circulating nurse's note (to confirm time reporting accuracy), any other documentation that might support services reported.
- IV. Compile findings and plan training and education
 - Don't lose momentum; provide timely training

What You Need To Audit Anesthesia

- CPT manual (AMA- current version)
- ICD-9-CM (WHO)
- HCPCS II (CMS)
- Anesthesia Crosswalk (ASA)
 - This links surgery codes to anesthesia service codes
- Relative Value Guide (ASA)
 - "Base units" found here
 - Like RVUs but defined by ASA
- Anesthesia record
- Surgeon's operative note



I. Getting Prepared

- Do not attempt to conduct an audit using outdated materials...it can cost you!
 - CPT®
 - ICD-9-CM
 - ASA Relative Value Guide
 - LCDs, NCDs, Payer Fee Schedules
- Develop and utilize an effective audit template
 - Capture patient demographics, Provider(s) of record, DOS, ASA/CPT codes, ICD-9 codes, medical direction items (e.g., induction, emergence, monitoring, etc.), medical direction modifier (i.e., QK, QX, QZ, etc.), time accuracy, ASA code (e.g., physical status), anesthesia method (e.g., GA, MAC, epidural, etc.), separately billables (e.g., post-op pain epidurals, Swan-Ganz catheter placement, central venous pressure lines, emergency intubations, critical care visits, etc.) and auditor's comments.

Use Comprehensive Audit Template

Patient Name:		Date of Service	Type of Anesthesia	CPT/ASA Coding	ICD-9-CM Modifier	Pre-Anesthetic Evaluation	Anesthesia Plan	Induction Monitor	Emerge	Avail	Post-Anesth Care	Time Accuracy	Separate Billable Items	Auditor Comment
Last	First													

II. The Sample Size

- Will your review be done prospectively or retrospectively?
- Generally, minimum of 10 cases should be selected. We have often suggested that 40 cases be reviewed to get the *full picture*.
 - Get a good case mix
 - Medicare claims
 - Medicaid claims
 - Private payers
 - Personally performed, medically directed




III. Select the Cases and Pull Records

- Make sure records are current (past 6 months)
- Obtain:
 - Pre-anesthesia evaluation and plan
 - Anesthesia records
 - Post-anesthesia records (if separate from record)
 - Procedure report (from hospital or surgeon)
 - Circulating nurse's note (compare time accuracy)
 - Billing history (if retrospective audit)
 - All other documents that may support medical necessity for selected services



Carefully Complete The Template

- **Patient Name: Last, First**
 - Some choose to utilize MR#
 - Check other variables to ensure patient accuracy
 - DOB, Middle Initial, etc.
- **Date of Service**
 - Compare DOS on the operative report and anesthesia record to that listed in billing history (CMS-1500)
- **Type of Anesthesia**
 - Check first the pre-anesthesia evaluation, then evaluate the anesthesia record to confirm accuracy
 - General
 - MAC
 - Spinal
 - Labor epidural



Carefully Complete The Template

- **CPT/ASA Coding**
 - Refer to the operative report and anesthesia record to confirm accuracy of CPT/HCPCS II codes
 - Consult the pre-anesthesia evaluation, anesthesia record, and plan to confirm the accuracy of physical status
- **ICD-9-CM**
 - Be sure that the post-operative diagnosis is utilized for reporting purposes
 - Open lines of communication with surgeon(s)
 - Be sure not to report rule-out or suspected conditions
 - Specificity and certainty
 - ICD-10-CM will require documentation of laterality (if applicable)
- **Modifier(s)**
 - Personally performed, MAC, medical direction, etc.
 - -QK, -QX, -AA, -QZ, -QS, etc...

Carefully Complete The Template

- **Pre-Anesthesia Evaluation**
 - Physical examination and evaluation prior to case
- **Anesthesia Plan**
 - What method of anesthesia is planned prior to case? We have found this to be a considerable compliance concern during audit
- **Induction**
 - Required for general anesthetic. Medically directed cases require MD "presence at induction"
- **Monitoring**
 - Required at "frequent intervals"
- **Emergence**
 - Required for general anesthetic. Medically directed cases require MD "presence at emergence"
- **Availability**
 - Must be available "for immediate diagnosis and treatment of emergencies"
- **Post-Anesthesia Care**
 - Required element of medical direction (e.g., to PACU, stable vitals)

Medically Directed Case Reminders

- Personal participation on the pre- and post-anesthesia care is *required* in medically directed cases
- The attending anesthesiologist who bills for medical direction must:
 - Perform the pre-anesthetic examination and evaluation,
 - Prescribe the anesthesia plan, and
 - Provide the indicated post-anesthesia care
 - *A case that begins as a teaching case (attending supervising one resident) may become a medically directed case if the attending becomes involved in a second case, even if only for a short duration (even if only for a minute)*
- In cases where care is “handed off” to a relieving anesthesiologist, it is not expected that both physicians would demonstrate “presence at emergence”.
 - May suggest forms are addressed beforehand by attending...
 - “Hand offs” should demonstrate availability and start/end times

True or False?

When calculating anesthesia time for a Medicare claim, the provider may select an additional 15 minute unit of time once the “midpoint” has been met (5 minutes).

- True
Incorrect
- False
Correct



Reset Questions

Carefully Complete The Template

- **Time Accuracy**
 - Time on Medicare claims is to be reported in minutes in the “units” field of CMS-1500
 - Compare reported time to the circulating notes
 - If “start” and “stop” times are routinely reported in increments of “0” and/or “5”, a problem may exist.
 - Educate attendings and residents as to the role of accurate time-keeping and impact on reimbursement/compliance
- **Separate Billable Items**
 - Certain items may be reported separately...(e.g., Swan-Ganz, post-op pain epidurals, TTE, emergency intubations, critical care, A-lines, CVPs, etc.)
 - We have often found A-lines, CVPs, epidurals documented and not reported (revenue loss)
 - The attending’s personal presence should be specifically demonstrated (or MD personal presence with resident).
- **Auditor Comments**
 - Detail findings in laymen terms. Do not make this field too “busy”.
BULLET POINTS!
 - If retrospective, be sure to confirm accuracy of payments based on payer contractual obligations


Chronic Pain and Critical Care Review

- Providers often select levels of E&M service that are not supported by documented levels of history and physical examination.
 - When selecting levels of E&M, always pay careful attention to the complexity of medical decision making
- Critical care visits are only supported when:
 - Time is adequately documented
 - 99291- 1st 30-74 minutes
 - +99292- each additional 30 minutes
 - Patient condition must consist of high complexity of medical decision making and pose threat to vital system function(s)

Obstetrical Anesthesia

- There is not one, single recognized method of reporting time for neuraxial labor analgesia
- The four (4) general options are:
 1. basic units plus patient contact time (insertion, managing adverse events, delivery, removal) plus one unit hourly;
 2. basic units plus time units (insertion through delivery), subject to a reasonable cap;
 3. single fee; or
 4. incremental fees based on the number of hours involved.

➤ Develop a policy!



IV. Training and Education

- One on one verses group session(s)
- Share findings in terms of both reimbursement and compliance
- Know the personalities and take a non-confrontational approach
- Tie \$\$ to your findings and demonstrate financial risks



Who Gets Audited and Why

- “Why was I selected for an audit?” is the most commonly asked question. The question is appropriate, and the answer varies with each area. Not all audits are selected in the same way.
- A practice can be selected for an audit if:
 - risk assessment factors are deemed high;
 - it has emerging compliance issues;
 - it is a core business process;
 - alleged irregular conduct has occurred;
 - there is a concern from the special investigative unit of a payer/carrier;
 - Disgruntled employee or patient

Auditing of Anesthesia Services

- Unlike most other physicians who are paid on a fee-for-service basis, anesthesiologists are paid according to a base-plus-time-plus-modifiers methodology that takes into account a wide variety of factors, including stringent regulations governing concurrency.
- One practical result is that anesthesia payment is highly dependent on careful documentation, which makes it more vulnerable to human error.
- Unique payment information requirements make anesthesia coding a special challenge.
- The difficulties also extend to the back end—
 - billing software designed for other specialties fails to meet many needs of the anesthesia practice.
 - The overall result for anesthesia practices is a greater danger of lost revenue and greater exposure to compliance risk.

Coding and Documentation Compliance

- Anesthesiologists are the only specialists who must meet all seven steps of medical direction when directing more than one case.
 - Failure to meet even one of them will invalidate a claim for medical direction payment, reducing it to medical supervision (and significantly lowering payment).
 - Confusion here can easily lead to overbilling and makes the process vulnerable to fraud.
- *More penalties and fines have been assessed against anesthesia practices for violation of Medicare medical direction guidelines than any other aspect of anesthesia billing.*

More Compliance Related to Medical Direction

- The compliance risk is billing for medical direction without having complete documentation to back it up.
 - If the Centers for Medicare and Medicaid Services audits an anesthesia practice and discovers inadequate documentation of medical direction, the practice will be required to pay back the difference between payments and what the documentation actually supports.

Concurrent Care

- When auditing for concurrent care, check for accurate documentation of:
 - Start and stop times and examine concurrency reports for any case time overlaps.
 - Make sure all providers are signing in and out of time logs on anesthesia records by themselves and are not rounding times (starts/stops on "0" and "5")
- Documentation to support concurrency must accurately track:
 - Type of provider (physician, resident, certified registered nurse anesthetist [CRNA], student CRNA) as well as relief providers for lengthy cases.
 - Make sure services are billed under the provider with the most time on a case and that billing software is calculating concurrent care properly.

Critical Reminders

- When auditing coding performance, pay attention to a handful of key issues.
 - Highest base unit that is appropriate for the anesthesia encounter.
 - Confirm appropriate modifiers, such as modifiers for patient age, physical status, emergency services, and complications. Depending on the payer and contract, these factors can lead to higher payment. Medicare does not pay QC or PS
 - CPT codes are crossing to the correct ASA codes in software maintenance files
 - There are more than 6,000 CPT surgery codes and only 350 ASA codes, and faulty crosswalks can result in major billing problems.

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