VENTRA Health

ANESTHESIA 101

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INTRODUCTION & OBJECTIVES

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AGENDA

1. **Introduction & Learning Objectives:** Who are we, why are we here?
2. **What Is Anesthesia?:** Definition, Types, Important Terminology
3. **Anesthesia Billing:** Units, Codes, Modifiers, Common Issues

"We tend to favour more traditional anaesthetic techniques here."

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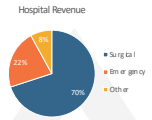
Why is this Important?

- **Impact of Surgical Services:**
  - 70% of hospital revenue
  - 40% of hospital spending
  - OR Cost: over $100/minute (including fully-loaded costs of all physicians & other providers)



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WHAT IS ANESTHESIA?

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Anesthesia Defined

From Greek anaisthesia - "without sensation"

"Insensitivity to pain, especially as artificially induced by the administration of gases or the injection of drugs before surgical operations"

"Loss of sensation, with or without loss of consciousness"

Anesthesiology is the practice of medicine dedicated to the relief of pain and total care of the surgical patient before, during and after surgery.
- American Society of Anesthesiologists

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Anesthesiology

Care of the patient before during and after surgery or other diagnostic and therapeutic procedures

- Evaluate and optimize any coexisting disease processes
- Deliver anesthesia and sedation
- Manage post anesthesia recovery
- Prevent and manage complications
- Practice of Acute and Chronic Pain Medicine
- Practice of Critical Care Medicine

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Acronyms

ASA	American Society of Anesthesiologists
AANA	American Association of Nurse Anesthetist
MD	Doctor of Medicine
DO	Doctor of Osteopathic Medicine
MDA	MD of Anesthesiology
CRNA	Certified Registered Nurse Anesthetist
SRNA	Student Registered Nurse Anesthetist
AA	Anesthesia Assistant

OR	Operating Room
PACU	Post Anesthesia Care Unit
PAT	Pre Admission Testing
MAC	Monitored Anesthesia Care
NORA	Non Operating room Anesthesia
POP	Post Op Pain
TOT	Turn Over Time
ASC	Ambulatory Surgery Center

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Revenue Cycle Acronyms

CPT®	Current Procedural Terminology	ICD-10	International Classification of Diseases 10th Edition
HCPCS	Healthcare Common Procedure Coding System	HIPAA	Health Insurance Portability and Accountability Act of 1996
CMS	Centers for Medicare & Medicaid Services	HCFA	Health Care Finance Administration
MCR	Medicare	MCD	Medicaid
EMR	Electronic Medical Record	EHR	Electronic Health Record
EOB	Explanation of Benefits	ERA	Electronic Remittance Advice
EDI	Electronic Data Interchange	HL7	Health Level Seven
DOS	Date of Service	DOE	Date of Entry
PA	Prior Authorization	EFT	Electronic Funds Transfer

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Revenue Cycle Acronyms

COB	Coordination of Benefits	KPI	Key Performance Indicator
AR	Accounts Receivable	NCR	Net Collection Rate
EOM	End of Month	PPU	Payment per unit
EOD	End of Day	PPC	Payment per Case
PTFL	Past Timely Filing Limit	DOP	Date of Posting
EIN	Employer Identification Number	TIN	Tax Identification Number
AIMS	Anesthesia Information Management System	AHRQ	Agency for Healthcare Research and Quality
ABN	Advanced Beneficiary Notice	AQI	Anesthesia Quality Institute

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Types of Anesthesia Providers

Provider	Details
Physicians	• Medical Doctor (MD) • Doctor of Osteopathy (DO) • Locum Tenens (Temporary Provider)
Other Providers	• Certified Registered Nurse Anesthetist (CRNA) • Anesthesia Assistant (AA)
Students	• Resident (MD/DO training to become Anesthesiologist) • Student Registered Nurse Anesthetist (SRNA)

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Sedation

- Sedation is a continuum, not a definite state
- Often times it is not possible to predict how a patient will react to medications
- Practitioner should be prepared to "rescue" a patient when their level of sedation becomes deeper than intended
- Individuals who are administering moderate sedation/analgesia should be able to rescue patients who enter a deep sedation
- Individuals administering deep sedation should be able to rescue patients who enter state of general anesthesia
- Rescue - qualified practitioner must be proficient in airway management and advanced life support

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Continuum of Sedation

	Minimal Sedation Anxiolysis	Moderate Sedation/ Analgesia ("Conscious Sedation")	Deep Sedation/ Analgesia	General Anesthesia
Responsiveness	Normal response to verbal stimulation	Purposeful** response to verbal or tactile stimulation	Purposeful** response following repeated or painful stimulation	Unarousable even with painful stimulus
Airway	Unaffected	No intervention required	Intervention may be required	Intervention often required
Spontaneous Ventilation	Unaffected	Adequate	May be inadequate	Frequently inadequate
Cardiovascular Function	Unaffected	Usually maintained	Usually maintained	May be impaired

American Society of Anesthesiologists™

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Minimal vs Moderate Sedation

- Minimal Sedation
  - Anxiolysis
  - Drug induced state
  - Patient responds normally to verbal stimuli
  - Airway and ventilation status normal
  - Cardiovascular function is not affected
- Moderate sedation
  - "Conscious Sedation"
  - Drug induced depression of consciousness
  - Patient responds purposefully to verbal commands
    - No stimulation
    - Tactile stimulation
    - Reflex withdrawal from a painful stimulus is NOT considered a purposeful response

https://www.asahq.org/standards-and-guidelines/continuum-of-depth-of-sedation-definition-of-general-anesthesia-and-levels-of-sedationanalgesia

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Deep Sedation/Analgesia vs General Anesthesia

- Deep Sedation/Analgesia
  - Drug-induced depression of consciousness
  - Patient cannot be easily aroused
  - Responds purposefully to following repeated or painful stimulation
  - Independent maintenance of ventilatory function may be impaired
  - May require assistance with airway
  - Spontaneous ventilation may be inadequate
  - CV function is usually maintained
- General Anesthesia
  - Drug-induced depression of consciousness
  - Patient is not arousable, even with painful stimulation
  - Often requires assistance maintaining patent airway
  - Positive pressure ventilation may be required due to depressed spontaneous ventilation or drug induced depression of neuromuscular function
  - CV function may be impaired

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What is MAC?

- MAC is a "specific anesthesia service performed by a qualified anesthesia provider, for a diagnostic or therapeutic procedure"
- Monitored Anesthesia Care (MAC)
  - Does not describe the continuum of depth of sedation
- Indications
  - "the need for deeper levels of analgesia and sedation than can be provided by moderate sedation (including potential conversion to general or regional anesthetic"

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How is Moderate Sedation different than MAC?

Moderate Sedation

- Physician supervises administration of sedative and/or analgesic medication during a diagnostic or therapeutic procedure
  - Allay anxiety
  - Minimize pain
- Physician performs procedure and is supervising sedation
- Intent to provide comfort and cooperation during a diagnostic or therapeutic procedure
- No intention of inducing dept of sedation that would impair the patients respiratory status
- Proceduralist is focused on completion of the scheduled procedure and may not be cognizant of pathophysiologic effects of medications given

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Monitored Anesthesia Care (MAC)

- Anesthesia provider required
- Requires periprocedural anesthesia assessment
- Management of patients actual or anticipated physiological derangements during a diagnostic or therapeutic procedure
- Provider focused only on patients airway and hemodynamic status and is prepared to convert to general
- Maximum depth of sedation in excess of that provided during Moderate sedation

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Monitored anesthesia care includes all aspects of anesthesia care – a preprocedure *assessment and optimization*, intraprocedure care and postprocedure management that is inherently provided by a qualified anesthesia provider as part of the bundled specific service. During monitored anesthesia care, the anesthesiologist provides or medically directs a number of specific services, including but not limited to:

- Preprocedural assessment and management of patient comorbidity and periprocedural risk
- Diagnosis and treatment of clinical problems that occur during the procedure
- Support of vital functions inclusive of hemodynamic stability, airway management and appropriate management of the procedure induced pathologic changes as they affect the patient's coexisting morbidities
- Administration of sedatives, analgesics, hypnotics, anesthetic agents or other medications as necessary for patient safety
- Psychological support and physical comfort
- Provision of other medical services as needed to complete the procedure safely.

https://www.asahq.org/standards-and-guidelines/position-on-monitored-anesthesia-care

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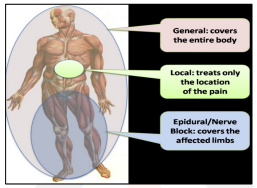
Types of Anesthesia

- General
- Monitored Anesthesia Care (MAC)
- Regional
  - Epidural
  - Spinal
  - Nerve Block
- Local



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Types of Anesthesia

- **General** - anesthetic agents administered to render the patient completely unconscious
- **Monitored Anesthesia Care (MAC)** – anesthesia provider continuously monitors patient with anticipation of administering general anesthesia if necessary
- **Moderate Sedation** - "Conscious Sedation" Drug induced depression of consciousness
- **Regional** - used to make a specific portion of the body numb to relieve pain or allow a surgical procedure to be performed
  - *Epidural* - a type of regional anesthesia frequently used during labor and delivery and surgery in pelvis and legs
  - *Spinal* - a type of regional anesthesia used for lower abdominal, pelvic, rectal or lower extremity surgery
  - *Nerve Block* – pain is blocked to a body region by injecting medication around a nerve
- **Local** – not separately billable

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MEDICAL DIRECTION

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What is required for Medical Direction?

For each case, the anesthesiologist must:

- Perform a pre-anesthesia **examination and evaluation**
- Prescribe the anesthesia **plan**
- Participate in the **most demanding parts** of the case (induction/emergence/monitoring)
- Ensure that any procedures in the anesthesia plan that he or she does not perform are performed by a **qualified anesthetist**
- Monitor the course of the case at **frequent intervals**
- Remain physically present and **available** for immediate diagnosis and treatment of emergencies
- Provide indicated **post-anesthesia care**

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What is Concurrency?

- Concurrency refers to to the maximum number of procedures that the physician is medically directing within the context of a single procedure and whether these other procedures overlap each other.
- Concurrency is not dependent on each of the cases involving a Medicare patient.
- For example, if an anesthesiologist medically directs three concurrent procedures, two of which involve non-Medicare patients and the remaining a Medicare patient, this represents three concurrent cases.

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Medical Direction vs Supervision (billing)

- **Medical Direction:** when an anesthesiologist is directing up to 4 concurrent qualified non-physician anesthetists
  - 1: up to 4 (max 1:2 for residents)
  - AND all 7 requirements, outlined on previous slide, are met
- **Medical Supervision (billing):** when the anesthesiologist is supervising 5 or more concurrent qualified non-physician anesthetist
  - 1: 5+
  - Performing other services while directing the concurrent procedures
  - 3 base units plus 1 additional unit if physician documents presence at induction

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ANESTHESIA BILLING

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Anesthesia Billing Basics

Necessary components to bill:

- Date of Service (DOS)
- Place of Service (POS)
- Mode/type of anesthesia
  - General
  - Regional
  - MAC
- Anesthesia Start & Stop times
- Surgical procedure code (CPT)
- Anesthesia Code (ASA)
- Diagnosis code (ICD-10)
- Configuration of anesthesia care team
- Any additional revenue opportunities
  - Lines/Blocks

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Anesthesia Billing Concepts

- Time Based Surgical Services
  - Base units plus time
  - Plus qualifying circumstances
  - Payment modifiers
- Obstetric Anesthesia (OB)
  - Base plus time
  - Flat fee
  - Face to face
- Flat Fees
  - Reported with CPT codes outside of the anesthesia code range (00100-01999)
  - Paid on fixed fee (not time dependent)
  - Example- post op pain blocks

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Anesthesia Base Units

Base Units reflect the complexity, risk and skill required to perform the service. (Multiple procedures report the procedure with the highest base units)

00790- Laparoscopic Gallbladder 7 units
00567- CABG on pump 18 units
00566- CABG off pump 25 units
00580- Heart Transplant 20 units

How do you figure out how many base units for a procedure?

- Laparoscopic gallbladder removal – CPT 45672
- CPT 45672 crosswalks to ASA code 00790
- 00790 = 7 base units

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Anesthesia Time Units

Anesthesia time represents the period of time with continuous presence of an anesthesia provider, during which there is a relationship of dependence between the patient and the provider

- Start Time: Begins when preparing the patient for the anesthesia service in the OR or equivalent area
- End Time: when the anesthesia provider turns over responsibility of the patient to non-anesthesia personnel in the PACU or ICU
- Rounding: times must be reported by the minute and NOT rounded

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Anesthesia Payment Modifiers (not all inclusive)

Modifier	Description
AA	Anesthesiologist: Used when anesthesia services are personally performed by the anesthesiologist alone.
QY	Anesthesiologist: Used when medical direction is provided to one CRNA by an anesthesiologist.
QK	Anesthesiologist: Used when medical direction is provided to two, three or four CRNA's on concurrent anesthesia procedures.
QX	CRNA: Used when service with medical direction is accompanied by an anesthesiologist.
QZ	CRNA: Used when the CRNA is working alone without any medical direction by an anesthesiologist
AD	Anesthesiologist: Used when medical direction is provided to 5 or more CRNA's on concurrent anesthesia procedures. (Ventra Health doesn't bill this modifier)
QS	Monitored Anesthesia Care
59	This is used for distinct procedural services.

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Anesthesia Physical Status Modifiers

Modifier	Description
P1	A normal healthy patient – 0 units
P2	A patient with mild systemic disease – 0 units
P3	A patient with a severe systemic disease (+ 1 unit)
P4	A patient w/ severe systemic that is a constant threat to life (+ 2 units)
P5	A moribund patient who is not expected to survive without the operation (+ 3 units)
P6	A declared brain-dead patient whose organs are being removed for donor purposes (0 units)

NOTE: Medicare & many other payers do not reimburse for physical status

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Qualifying Circumstances

Code	Description
99100	A patient is younger than 1 or older than 70 (+ 1 unit)
99140	Emergent case (+ 2 units)
99315	Controlled hypotension (+ 5 units)
99116	Controlled hypothermia (+ 5 units)

NOTE: Medicare & many other payers do not reimburse for qualifying circumstances

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Anesthesia Coding

Anesthesia coding is complicated and requires attention to detail

- Determine appropriate CPT code(s) for surgery performed (Operative Report)
- Crosswalk CPT code to appropriate ASA code
- Determine base units
- Determine time units
- Assign correct modifier to identify the provider of anesthesia services
- Assign modifier for MAC if applicable
- Assign appropriate qualifying circumstance code
- Determine appropriate CPT code(s) for additional procedures or services provided (Holding/PACU records)
- Determine total units for anesthesia services

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Anesthesia Charge Structure

- Anesthesia Professional claim
  - (Base units + time units)
- 72 year old patient with history of uncontrolled HTN with ruptured appendix (possible abscess) for emergent appendectomy. Anesthesia time 60 minutes.
  - 00840- *Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified*
    - Base Units- 4
    - Time Units- 4
    - Physical Status modifier +1 (uncontrolled HTN - P3)
    - Qualifying circumstance + 3 (age >70 (99100), emergent procedure (99140))
  - Total Billed Units– 12 units x 2 claims (assuming MCR is payer)

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Anesthesia Reimbursement

For medically directed cases

For "normal" surgical procedures:

Base Units + Time Units + Modifying Units = TOTAL UNITS

TOTAL UNITS x Conversion Factor = Allowed Reimbursement Amount

- Most payers want split claims but some want single claim
  - Split claim = one claim for Physician/ one claim for non physician
- Reimbursed per contract
  - 50/50, 60/40
- Conversion Factor = the payer's contracted rate
- Time units- *may be rounded or may be paid at the tenth of unit*

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Obstetric Anesthesia

- 01967- Anesthesia for neuraxial labor analgesia/anesthesia
  - Reimbursement may vary based on payer contract
    - Base unit plus time
    - Base unit plus time subject to cap
    - Base unit plus one unit per hour plus direct patient contact time
    - Base unit plus one unit per hour plus four units for last hour
    - Face to face time
    - Incremental time-based fee
    - Single flat fee
- 01968- Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia. (add on code)
  - Base + time

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Ancillary Services (flat fee)

Billed with CPT codes = flat fee. Reimbursed according to payer fee schedule.

- Invasive Lines
  - Arterial Line (36620)
  - CVP (36555/36556)
  - Swan-Ganz Catheter (93503)
  - TEE (93313, 93312)
- Other Non-OR Anesthesia services
  - Blood patches
  - Emergency intubations
- Post-Op Pain Management
  - Surgeon request
  - Pain Blocks
    - Femoral Nerve Block
    - Intercostal Block
  - Post op pain catheters
    - Epidural Catheter
  - Ultrasound Guidance
    - Must keep images
- Consultations
  - Trauma
  - Cancer Pain

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