MEDCO FORUM®

PRESENTING INNOVATIVE PRODUCTS & SERVICES TO HEALTHCARE PROFESSIONALS

## Medco Forum Presents: Anesthesiologists paid $50 Million in penalties in the past 2 years!

Can You afford to pay out millions because your staff or billing company wasn't following, or did not know the latest rules?

The OIG doesn't care if your error is inadvertent. For OIG, the person who gets the payments is the responsible party. The OIG has very specific compliance requirements for physicians: you can download them here.

Are you confident about the following topics?

- **Medical direction: are all 7 steps performed and documented?**
- **Anesthesia time: does your "clock" start and stop when it should?**
- **OB anesthesia billing: is it per payer contract?**

Each of these areas represents substantial audit risk. You should have written procedures. To assess your current risk: contact us now to learn how an inexpensive compliance review or documentation audit can help you sleep better and improve your operations.

- Sign up for our anesthesia newsletter to stay informed of OIG activity and rule changes.

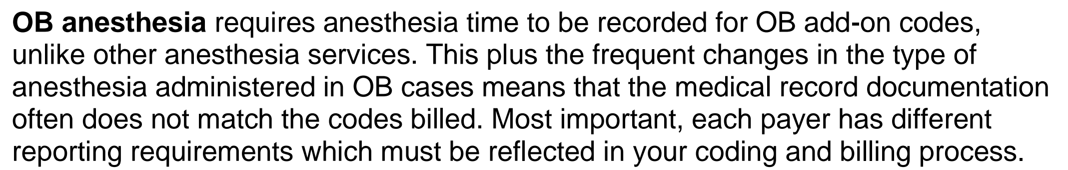
**Medical direction** is often billed when documentation doesn't support it. Most often missed:

- Performing the pre-anesthetic exam and evaluation,
- Being "immediately available" at all times,
- Providing the post-anesthesia care, and/or
- Being present for the most demanding procedures.

Also, the OIG Work Plan for 2015 (see below) highlights "personally performed" claims that should have been "medically directed."

**Anesthesia time** has very clear guidelines. "It starts when the anesthesia practitioner begins to prepare the patient for anesthesia services in the OR and ends ... when the patient may be placed safely under postoperative care."

- Start and stop times must be reported in minutes: do not round!
- Requires continuous presence of the anesthesiologist or CRNA
- Pre-op exam time is not included
- Use your watch, not the OR clock since clocks vary which could cause discrepancies



**OB anesthesia** requires anesthesia time to be recorded for OB add-on codes, unlike other anesthesia services. This plus the frequent changes in the type of anesthesia administered in OB cases means that the medical record documentation often does not match the codes billed. Most important, each payer has different reporting requirements which must be reflected in your coding and billing process.

Anesthesia coding and billing can be complicated, therefore, it is not always easy to make the right choices. Contact us now to learn more about education and other tools available to make sure you are fully compliant.

Don't be one of the anesthesia groups that missed the warming signs!

Bill Gilbert
AdvantEdge Healthcare Solutions
www.ahsrcm.com/anesthesia/billing/
877 501-1611

- Sign up for our anesthesia newsletter to stay informed of OIG activity and rule changes.

PS. HIPAA security is another important mandate, especially in light of recent public breaches of patient data. Download our HIPAA security checklist and learn how to dramatically reduce your risk.

OIG WORK PLAN 2015
Anesthesia services—Payments for personally performed services. We will review Medicare Part B claims for personally performed anesthesia services to determine whether they were supported in accordance with Medicare requirements. We will also determine whether Medicare payments for anesthesia services reported on a claim with the "AA" service code modifier met Medicare requirements. Physicians report the appropriate anesthesia modifier code to denote whether the service was personally performed or medically directed. (CMS, Medicare Claims Processing Manual, Pub. No. 100-04, ch. 12, §50) Reporting an incorrect service code modifier on the claim as if services were personally performed by an anesthesiologist when they were not will result in Medicare's paying a higher amount. The service code "AA" modifier is used for anesthesia services personally performed by an anesthesiologist, whereas the QK modifier limits payment to 50 percent of the Medicare-allowed amount for personally performed services claimed with the AA modifier. Payments to any service provider are precluded unless the provider has furnished the information necessary to determine the amounts due. (Social Security Act, §1833(e).)