INTRODUCTION

Anesthesia is one of the most complex medical specialties from a billing standpoint. When you send a claim to a payer, you are attesting that all services on that claim are true and appropriate, and adequate documentation exists to support any item billed. With the myriad rules dictating when and how services must be billed, it is imperative for you to understand the rules governing your practice.

You are not expected to know every billing rule, but you must know how your documentation drives the billing process. Inadequate documentation leaves you open to significant claims delays while the needed information is obtained; or worse, significant compliance risk if the right questions are not asked to ensure the claim is accurate.

This guide will outline the critical billing rules for anesthesia providers and provide clear instructions on how to document to ensure each scenario is captured correctly and completely.

BASE UNITS

If multiple surgical services are performed, document each service on the record. While the surgeon may report multiple services on his claim, anesthesia providers can only report a single service. Including all services in your documentation will ensure the service with the highest base unit value is billed.

TIME UNITS

Anesthesia time is defined as “the continuous, actual presence” of the anesthesia provider. Anesthesia time is one of the highest risk areas for inadequate documentation and inappropriate billing.

Start Time: Begins when the anesthesia provider starts preparing the patient for the anesthesia service in the OR or equivalent area. Start time must be tied to an event in the record (IV placement, Versed administered, 1st vitals...). Start time cannot be tied to patient ID, chart review, or patient assessment.

End Time: When the anesthesia provider is no longer in personal attendance, i.e., when the patient may be safely placed under post-operative supervision. This is the “transfer of care” time.

Discontinuous Time: When the anesthesia time is broken into two or more separate periods. This is most commonly due to a case delay, early administration of Versed, or a primary anesthetic block placed in advance of
the procedure. In these cases, two sets of start and stop times must be recorded, capturing each period the anesthesia provider was present with the patient.

**Relief:** Relief must be clearly captured, noting the relieving provider and the time he/she assumed care of the patient.

**Time Rounding:** Anesthesia times should always be documented to the nearest one (1) minute. Auditors are trained to look for high rates of times ending on the fives (:00, :05, :10, :15...).

**Time Padding:** Time should never be added before the true start time or after the true end time. Further, attendance with the patient should Average PACU time is generally 7 minutes. If your case requires you to remain present substantially longer than 7 minutes, the record should contain a note stating the reason (vitals unstable, uncontrolled pain...).

**Mode of Anesthesia**

It is crucial to clearly document the mode of anesthesia. While there may be multiple clinical techniques for anesthesia administration, only the following are relevant from a billing standpoint:

- Monitored Anesthesia Care (MAC)
- General Anesthesia
- Regional Anesthesia (spinal, epidural, block)

The terms used on your record should reflect one or more of these three modes of anesthesia to ensure proper billing. Terms like “IV sedation” or “inhalation anesthesia” may not be uniformly understood.

When performing monitored anesthesia care, it is important to note if the patient loses the ability to respond purposefully, the mode of anesthesia should be reported as “general”. When reporting regional blocks in conjunction with another mode of anesthesia, there are specific criteria on when the epidural, spinal, or block placement can and cannot be reported separately.

**Block can reported separately:**

- Regional Block + General *(block can be billed)*
- Epidural/Spinal + General *(epidural/spinal can be billed)*
- Epidural/Spinal + Regional Block *(block can be billed)*

**Block is considered an integral part of the anesthetic and cannot be reported separately:**

- Regional Block + MAC *(block cannot be billed)*
- Epidural/Spinal + MAC *(epidural/spinal cannot be billed)*

**Modifying Units**

The following items, when documented may increase your billable units. Note that not all payers recognize each of these for additional reimbursement.

<table>
<thead>
<tr>
<th>Physical Status Modifiers</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1 Normal, healthy patient</td>
<td>0 units</td>
</tr>
<tr>
<td>P2 Mild systemic disease</td>
<td>0 units</td>
</tr>
<tr>
<td>P3 Severe systemic disease</td>
<td>1 unit</td>
</tr>
<tr>
<td>P4 Severe systemic diseases, constant threat to life</td>
<td>2 units</td>
</tr>
<tr>
<td>P5 Moribund patient who is not expected to live without the operation</td>
<td>3 units</td>
</tr>
<tr>
<td>P6 Declared brain dead donor</td>
<td>0 units</td>
</tr>
</tbody>
</table>

For specific examples of conditions within each physical status level, please see the ASA’s list titled “ASA Physical Status Classification System” under the “Administration” section here: [https://www.asahq.org/quality-and-practice-management/standards-and-guidelines](https://www.asahq.org/quality-and-practice-management/standards-and-guidelines)

<table>
<thead>
<tr>
<th>Qualifying Circumstances</th>
<th>Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>99100 Extreme Age &lt;1 or &gt;70</td>
<td>1 unit</td>
</tr>
<tr>
<td>99140 Emergency condition</td>
<td>2 units</td>
</tr>
<tr>
<td>99116 Utilization of total body hypothermia</td>
<td>5 units</td>
</tr>
<tr>
<td>99135 Utilization of controlled hypotension</td>
<td>5 units</td>
</tr>
</tbody>
</table>

Emergency condition should only be noted if there is a significant risk to life or body part if surgery is not performed. The following, alone are not emergencies: Surgery on nights or weekends, labor analgesia, C-sections absent distress or other extenuating circumstances.

**Field Avoidance and Positioning**

Any procedure around the head, neck, or shoulder girdle, requiring field avoidance, or any procedure requiring a position other than supine or lithotomy, has a minimum base value of 5.

**Diagnosis Documentation**

Every item billed on a claim must be assigned a primary diagnosis supporting the need for the billed service. The following are common diagnosis documentation deficiencies:

**Rule Out:** Common example is “rule out appendicitis”. If the appendicitis cannot be confirmed, the presenting sign/symptom should be documented, i.e., right lower quadrant abdominal pain.
Status Post: Common example is “status post total knee”. The exact reason for the procedure must be defined. i.e., is this for hardware removal? Is it due to infection?

C-Section Following Vaginal Attempt: We commonly see no diagnosis listed in this scenario. The reason for the C-section must be documented. i.e., breech, failure to progress, fetal distress, etc.

Incompatible Diagnoses: When multiple procedures are performed, or when a patient presents with “pain” and ends up in surgery, we often only receive the pre-op diagnosis which may not support the eventual procedure, or the secondary procedure that was also performed. We must receive all applicable post-operative diagnoses.

PROCEDURE DOCUMENTATION
Complete and accurate documentation of the procedure performed is critical to proper billing, as coding of the procedure determines the charge for each case. Procedure errors can lead to both over and under payments.

COMMON UNDER-BILLED ITEMS
– Use of one-lung ventilation (+2 units)
– Upper vs lower abdomen (+1 unit for upper)
– Arthroscopic vs. open procedure (+2 units for open)
– Fracture location (head, neck, shaft) (units vary)
– Diagnostic vs. surgical procedure (+1 unit for surgical)
– On or off bypass pump (varies 3-10 units)
– Spinal instrumentation or multiple levels (+3 units)

COMMON PROCEDURES WITH INSUFFICIENT DETAIL

<table>
<thead>
<tr>
<th>Integumentary System</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>– Laceration/lesion size in centimeters</td>
<td></td>
</tr>
<tr>
<td>– Repair type (simple, intermediate, complex)</td>
<td></td>
</tr>
<tr>
<td>– Full vs split thickness grafts</td>
<td></td>
</tr>
<tr>
<td>– Degree of burn + TBSA (using rule of 9s)</td>
<td></td>
</tr>
<tr>
<td>– Body site (arms, legs, chest, back)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Musculoskeletal System</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>– Fractures – Exact bone/region + open vs. closed</td>
<td></td>
</tr>
<tr>
<td>– Type of tendon repaired (flexor/extensor)</td>
<td></td>
</tr>
<tr>
<td>– Type of flap (pedicle, muscle, myocutaneous)</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Cardiovascular</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>– CABG - # veins/arteries + on/off pump</td>
<td></td>
</tr>
<tr>
<td>– Pacemakers – atrial and/or ventricular electrodes + single or dual pulse generator</td>
<td></td>
</tr>
<tr>
<td>– Clot removal method (angioplasty, thrombectomy, thrombolysis)</td>
<td></td>
</tr>
</tbody>
</table>

– CVC – Tunneled? Cut down?

Male Genital System
– Prostatectomy Type – Perineal, radical, suprapubic, retropubic
– Orchiopexy/Orchietomy Approach – Inguinal or abdominal

Female Genital System
– Weight (in grams) of vaginal hysterectomy
– Labor epidurals: Time of delivery
– Labor Epidurals: Face to face contact time intervals (when required by payer)
– Labor to C-Section: Reason for the transition to C-Section (i.e., breech, failure to progress...)

CANCELLED CASES
If a case is cancelled, the following documentation elements must be provided:
– Reason for cancellation
– Was it canceled before or after administration of the primary anesthetic?

COSMETIC CASES
Cosmetic procedures are typically not billable to a patient’s insurance company – this include any time spent on cosmetic portions of an otherwise billable service. When cosmetic services are performed, you must provide two sets of time:
– Start and end time of the total case, and
– Start and end time of the cosmetic portion of the procedure.

INFORMATION REQUESTS
If Medac’s coders do not have enough information to accurately code a case, you will receive an Information Request. It is your duty to respond to this request as quickly as possible with the needed information so the case can be coded and billed.

AMENDING THE RECORD
If due to an Information Request or other reason, you must update the medical record, the following guidelines apply:

Late Entries: Information that was mistakenly omitted should be added ASAP if there is total recall

Corrections: Draw a single line through the errant data (never write over or obliterate the errant data). Enter the correct data in an adjacent space.

For ALL Revisions: Only the provider on the case should revise the record. The provider must add his/her
signature or initials and date next to the revision. A reason for the revision should be noted.

**MEDICAL DIRECTION**
If your practice utilizes a medical direction anesthesia care team, there are documentation and care guidelines that must be met to ensure proper billing. This involves an anesthesiologist medically directing 1-4 CRNAs or AAs. There are strict reimbursement penalties if the anesthesiologist oversees a 5th case, even if for only 1 minute.

**WHAT THE ANESTHESIOLOGIST MUST DO**
1. Perform a pre-anesthetic examination and evaluation
2. Prescribe the anesthesia plan
3. Personally participate in the most demanding procedures in the anesthesia plan, including induction and emergence
4. Ensure that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified anesthetist
5. Monitor the course of anesthesia administration at frequent intervals
6. Remain physically present and available for immediate diagnosis and treatment of emergencies
7. Provide indicated post-anesthesia care
   *Must be documented by the anesthesiologist*

**OTHER SERVICES THE ANESTHESIOLOGIST MAY PERFORM**
1. Address emergency of short duration in immediate area
2. Administer an epidural to ease labor pain
3. Perform periodic, rather than continuous, monitoring of an obstetrical patient
4. Receive patients entering the operating suite for the next surgery
5. Check on or discharging patients from the recovery room
6. Coordinate scheduling matters

**TEACHING SCENARIOS**
If your facility utilizes any Residents or SRNAs, you must clearly document one of the following:
- Personally present for the entire case
- Immediately available throughout the entire case

There are numerous guidelines governing anesthesia teaching scenarios. Consult your Compliance Officer to ensure you know and meet each requirement.

**SURGICAL SERVICES BY ANESTHESIA**
There are multiple services where the anesthesiologist acts as the surgeon. These are commonly referred to as “flat fee” services because the anesthesia provider is paid a flat fee schedule rate for performing the procedure (opposed to base + time units).

**LINE/MONITOR PLACEMENT**
Clearly document the following:
- Type of line/monitor (CVP, Arterial, Swan Ganz)
- Who placed it
- Where it was placed anatomically
- Start and stop time of placement
- Whether or not ultrasound guidance was used

**POST-OPERATIVE PAIN MANAGEMENT**
Clearly document the following:
- Who placed it
- Where it was placed (name the site/nerve)
- Single or continuous
- Start and stop time of placement
- Placed for post-operative pain control
- Placed at surgeon’s request
- Whether or not ultrasound guidance was used

Daily rounding is not billable on the day of placement. Daily rounding can be billed on subsequent days, but there must be sufficient documentation to bill for the visit (a basic S.O.A.P note is acceptable). A log with nothing more than a signature and date is not sufficient to bill a follow-up visit. If an epidural catheter was used, note if the catheter is still in place at the time of the follow-up visit.

**ULTRASOUND GUIDANCE**
Ultrasound guidance for line and/or block placement can be billed to most payers. The following must be present in the record to bill for ultrasound guidance:
- Permanent, retrievable images
- Formal report including measurements (when clinically indicated) and a description of the localization process.

**TIME FOR LINE AND BLOCK PLACEMENT**
Payers will not reimburse for time spent placing a line or block while the patient is awake. Blocks and lines can be placed at various times throughout the anesthesia service. The key factors are (1) Anesthesia Start Time, and (2) Administration of the primary anesthetic. If your line or
block is placed within this window, the time spent placing the line/block must be deducted from the total anesthesia time. There is no need to deduct time if it is billed before or after this window. See chart below for an example:

The following is a good cheat sheet for what to document for TEEs:

<table>
<thead>
<tr>
<th>Check only one:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic</td>
</tr>
<tr>
<td>Monitoring</td>
</tr>
<tr>
<td>Probe Placement Only - No Interpretation by Anyone</td>
</tr>
<tr>
<td>Probe Placement Only - Interpretation by Different Provider</td>
</tr>
<tr>
<td>Probe Placement and Interpretation, Both by You</td>
</tr>
<tr>
<td>Interpretation Only</td>
</tr>
<tr>
<td>Check one, both, or neither:</td>
</tr>
<tr>
<td>Pulsed Wave/Spectral Display</td>
</tr>
<tr>
<td>Color Flow Velocity Mapping</td>
</tr>
</tbody>
</table>

**TEE**

TEE’s require special training and certification. Certification Requirements vary by state. Medicare and most other payers will only reimburse diagnostic TEEs. **Key factors in determining if a TEE is billable:**

- **Timing:** Non-billable if placed intra-operatively
- **Context:** Must be “unrelated to the intraoperative anesthesia service”
- **Completeness:** Probe placement can only be billed if interpretation is completed (by you or someone else)
  - Exam of all 4 cardiac valves for stenosis and regurgitation
  - Exam of all 4 cardiac chambers for structure and function
  - Exam of the visible portions of the great vessels of the chest
  - Acquisition of 28 views

**CONCLUSION**

These are the most common areas of concern for anesthesia providers, but there are many nuances and other items that may apply in certain instances. If you have any questions about the material presented here or items not discussed in this document, please contact your Compliance Officer.

Disclaimer: This is intended as a resource for general compliance guidance applicable in most situations. Each practice and/or payer may present variables that add to, contradict, or otherwise modify all or parts of this guidance. Consult your Compliance Officer with any specific questions.