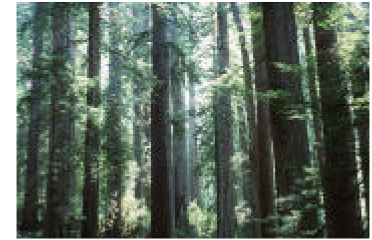
Volume 2 Issue 2 Summer 2003



Anesthesia Billing,

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CODING CHANGES

TEEs

In April, anesthesia providers were told they would no longer be paid separately for intraoperative transesophageal echocardiography, due to a recent major shift in Medicare policy. The Correct Coding Initiative (CCI) reset the modifier indicator to 0, indicating modifiers will no longer override and unbundle these codes. According to the American Society of Anesthesiologists (ASA), this change contradicted the CCI narrative section, which states that diagnostic TEEs are payable with the –59 modifier. Through ASA and it's efforts, lobbying on the federal and regional levels, the National Correct Coding Initiative (CCI) restored the old modifier indicator, allowing TEEs to get paid intraoperatively. The April change was especially bad for those who specialize in cardiac anesthesia. TEE codes, are once again separately billable using the –59 modifier.

Post-Op Pain, Daily Management

A recent change requiring the use of Evaluation and Management (E/M) codes, 99231—99233, for subsequent daily management of an indwelling spine catheter may be changed to return to the use of 01996 in 2004. Currently we are directed to use subsequent daily management codes if the catheter is placed as a separate procedure from anesthesia. This has caused problems with identifying the original source of anesthesia. ABI has followed the recommendation of Alexander Hannenberg, MD, chair of the ASA economic committee, and will not bill using the E/M codes until October 15th when the HIPAA electronic transaction standards will require us to follow the CPT 2003 regulations without exception.

Fluoroscopy

The use of fluoroscopy with spinal injections such as epidurals is increasing, partly because it allows the physician to more accurately inject the medication. Interestingly, so are the claim denials containing fluoroscopy. It is suggested by some, the success of epidural steroid injections without fluoroscopy are less effective, less accurate, and potentially more dangerous.

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MONITORED ANESTHESIA CARE AND MEDICAL NECESSITY

Many of you are involved in providing either Monitored Anesthesia Care (MAC) or have decided to use Propofol during gastrointestinal (GI) endoscopies to avoid the current MAC payment denials. If Propofol is medically necessary for each patient it should not pose any billing or compliance problems. However, you should not be making blanket treatment decisions based on reimbursement. All services billed must be medically necessary, whether billed to Medicare or other third party payers, and must be supported in the medical records. If it isn't written—It didn't happen.

Devonna Slater, President of Auditing for Compliance and Education, Inc., Leawood, KS, has been quoted to encourage communication with patients and payers if the GI doctor recommends the use of Propofol.

These physicians do not want to administer it, nor do they want the responsibility of patient safety when other drugs, Versed or Demerol are used. The use of Narcan can cause cardiac problems and its action to reverse the narcotic can wear off before the action of the narcotic wears off. With the 2-hour recovery room time associated with the use of Narcan, physicians are slowed from their desired 45-minute discharge rate.

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President's Corner

Philip R. Blann
President
Anesthesia Billing, Inc.

"...we are always checking and looking at the data we receive."

As I am trying to finish this newsletter and get it off to the press, I could not help but notice the calendar says September and this is our Summer issue. Our summer, like many of yous, passed before it began. Our oldest daughter graduated from high school in May and began a summer of preparation to move her into college. Our other three daughters kept busy with all they do—sports, choir, and now beginning dance and piano. We are in the final stages of a remodeling project where we basically gutted the girls bathroom to install a shower. We also helped move my dad from Texas to Kansas. Please ignore the inconsistency in the issue and hopefully we have given you some added insight to what is happening in the office.

In this issue we have returned to issues surrounding procedure coding and billing. HIPAA news, which has dominated our previous newsletters, is still a constant and ever present factor. I will try to continue to inform you regarding HIPAA regulation, as I know it, but feel it is just as important to return to billing issues. This newsletter appears to contain a laundry list of these billing issues, partly due to our concentration on HIPAA, partly due to the changes we have seen in 2003.

Many of our clients ask if we can offer coding services. Having three coders on staff, two of which are certified, we are always checking and looking at the data we receive. We are starting to hear that before we can offer coding services, a copy of the operative report, the anesthesia record and any other orders or notes will be required before we can help in this manner.

What is even more alarming, is the request by several billing companies requiring these documents for all patients, coded or not. We support the need for these documents when we are asked to code, but feel they only clutter our files if we are not coding. For those of you who code, we will audit these records in the post payment compliance arena, comparing what was actually billed to what is written in the record. For those few of you who are asking us to code for you, you might begin now working with your facility on how these documents can be provided. I do believe this will be an issue in the near future.

Enjoy the autumn and do not forget to stop long enough to see the leaves,

Calendar

October 16, 2003 Transactions and Code Sets—Deadline.

November 27, 2003 Thanksgiving, Holiday Closing

November 28, 2003 Holiday Closing

December 25, 2003 Christmas, Holiday Closing

January 1, 2004, New Years Day, Holiday Closing

abinsights Contact Information

abinsights readers are invited to submit comments, questions, tips, and suggestions for articles on any subject related to billing, collections, coding, reimbursement, and compliance. Send to: Anesthesia Billing, Inc., 423 SE 10th Street, Newton, KS 67117-4409. Phone 316-282-4321. Fax 316-282-4322.

Our purpose is to help you meet inevitable challenges. We hope to deliver practical knowledge and solutions drawn from top resources and business publications in every issue, knowledge you can use today.

Reasonable attempts have been made to be accurate. However, medical billing, collections, coding and compliance are part science, part art, and even experts sometimes differ. Neither Anesthesia Billing, Inc., the editors, publisher, contributors, or consultants warrant or guarantee the information contained will be applicable or appropriate in all situations. For information specific to your practice, consult a qualified professional.

The information included in this publication is provided, among other things, to alert you to legal developments and should not be considered legal advice. Specific questions about how this information affects your particular situation should be addressed to your attorney.

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Monitored Anesthesia Care and medical necessity—Continued

(Continued from page 1)

If you are one of these providers using Propofol, make sure you are marking your encounter forms for general anesthetic rather than MAC commonly associated with the use of Versed or Demerol.

If not medically indicated and you are asked to continue to provide more traditional MAC care for GI endoscopies, you are still faced with medical necessity issues. There is an increasing frequency, by payers, to consider the services to provide continuous evaluation of various vital physiologic functions and the diagnosis and treatment of any deviations, to be nursing duties and content of care normally provided by the facility or physician. Appropriate payment is allowed if the anesthesia service, provided by an anesthesia provider, is reasonable and medically necessary.

Medicare's National Coverage Policy has been interpreted by intermediaries to limit payment to anesthesia providers if medical necessity is not supported. It is their belief these procedures do not usually require anesthesia services, and only consider reimbursement when the patient's condition requires it. Medical necessity for anesthesia services is different than medical necessity for the Gastrointerologist. Anesthesia presence varies and would include patient conditions related to Diabetes (severe), morbid obesity (greater than 200% ideal body weight), certain psychosis conditions, cardiac disease, COPD, pulmonary disease, renal or hepatic failure, or severe allergic reactions.

We are seeing an increase by payers questioning MAC anesthesia not only in GI cases, but also eye cases and simple lesions.

ABN…Costing you Money?

Advance Beneficiary Notice (ABN)

If you are not using Advance Beneficiary Notices (ABN) to inform patients when Medicare may deny payment because of medical necessity, it is costing you money. This waiver is Medicare's way of protecting patients from surprise medical bills when the carrier does not agree the services merit separate payment. You are required to use the current ABN form developed by CMS in 2002 . This form should always be used when you believe a claim will be denied as not necessary. You would not use the ABN when a service is not covered by law, i.e. cosmetic surgery. Just using the ABN is not always enough to protect reimbursement. It must be completed on a case specific basis and must be completed correctly. Every ABN must contain the practice name, address and phone number. It must be signed and dated by the patient prior to services being rendered. And, the patient must receive a copy of the signed ABN.
The current ABN, June 2002, is enclosed.

"If you are not using the ABN to inform patients when Medicare may deny payment because of medical necessity it is costing you money."

The Firm is pleased to have been selected to co-sponsor **abinsights**.

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Pain Relief for Pain Relievers

Commercial carriers like Aetna and Cigna are calling for fluoroscopy to be bundled into injection procedures. Their argument is, ironically, this should be the standard of patient care and included in all cases. CPT coding guidelines indicate fluoroscopy, 76005, should be billed separately because it is not required. Medicare currently follows the CPT coding guidelines.

Teaching Rules

Payment policies for teaching anesthesiologists will be studied by Centers for Medicare and Medicaid Services (CMS). Currently a teaching anesthesiologist directing one resident gets full reimbursement for the anesthesia fee. However, should the anesthesiologist direct a second resident, medical direction rules apply and the physician fee drops to 50% on each case. Recall, CRNAs supervision of student nurses changed in 2002 allowing them full base value of the procedure plus any face-to-face documented time. We will continue to monitor any changes in procedure.