

Anesthesia FAQs from Ohio Medicare

The answers to these FAQ are PalmettoGBA's modified responses to a series of questions known as the "Georgia Guidelines" developed by the Georgia Society of Anesthesiologists and published in the Georgia Carrier's November 1999 newsletter." *These were published in the Ohio Society of Anesthesiologist newsletter Fall 2004 and that according to OSA these questions and answers were approved by the Ohio Part B carrier Palmetto GBA.*

Q1.

CMS has stated that the medically directing anesthesiologist may perform other duties concurrently to include: addressing an emergency of short duration in the immediate area; administering an epidural or caudal anesthetic to a patient in labor; performing periodic, rather than continuous, monitoring of an obstetrical patient; receiving patients entering the operating suite for the next surgery; checking or discharging patients in the PACU; and coordinating scheduling matters. Do you agree that the medically directing anesthesiologist may perform duties such as placement of lines and epidurals in the holding area consistent with this policy?

A1.

Yes, we agree that such duties are reasonable, consistent with sound medical practice, and would not cause the medically directing anesthesiologist to be in violation of CMS' rules for medical direction. As long as the medically directing anesthesiologist "remains physically present and available for immediate diagnosis and treatment of emergencies" (rule number "vi" of the CMS "seven commandments"), we would agree that the following procedures would be an illustrative but not exclusive list of allowed interventions:

1. Placement of a Swan-Ganz catheter, central line, or arterial line.
2. Placement of an epidural catheter for post-operative analgesia or in preparation for subsequent surgery (for a "to follow case").
3. Placement of other peripheral nerve blocks prior to subsequent surgery, to include brachial plexus blocks, ankle blocks, femoral nerve blocks, etc.

Q2.

Rule "v" states that the medically directing anesthesiologist "monitors the course of anesthesia at frequent intervals." How often must the anesthesiologist perform such monitoring, and how should this be documented on the chart?

A2.

The medically directing anesthesiologist is specifically required to document presence at induction, emergence and key portions of the case. CMS intends for the medically directing anesthesiologist to personally document that all of the seven requirements were met. No specific statement from CMS regarding the frequency of, or the proper format for documentation of periodic monitoring has been published. It is acceptable for the medically directing anesthesiologist to document periodic monitoring by attestation

on the anesthetic record or by indicating presence on a timeline if possible.

Q3. Please define “remains physically present and available for immediate diagnosis and treatment of emergencies” as stated rule “vi”.

A3.

We would agree that some degree of clinical relevance must be applied to this rule. Differences in geographic design and size of facilities, severity of illness of patients, and demands of particular operations prevent any one answer from being sufficient in all cases. Reasonable clinical judgment must therefore suffice as our best answer.

Q4.

Do you agree that there is no definable period of induction or emergence for MAC and regional anesthetic cases, and that therefore the medically directing anesthesiologist need not indicate presence for induction and emergence for these cases?

A4.

We agree. Indeed, in the Federal Register from November 1998, HCFA stated “However, since 1983, other types of anesthesia care, such as regional anesthetics and monitored anesthesia care have become more common. One of our objectives was to revise the current requirement so that it is consistent with current anesthesia practices. As a result, we have decided that the medically directing physician must be present at induction and emergence for general anesthesia. That final requirement is as follows: The medically directing physician participates in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence.” We would expect the medically directing anesthesiologist to indicate continuous availability for the MAC or regional anesthetic case in the record and to provide monitoring as indicated in Q2 above, but would not expect any notation regarding induction or emergence, since these terms have no meaning for MAC or regional cases.

Q5.

Do you agree with the following definition of emergence? “Emergence, for the purposes of complying with the medical direction requirements of Medicare cases, is the period beginning with the cessation of delivery of anesthetic agents and ending at the time the patient is turned over to the staff of the recovery room or other qualified personnel (ICU, etc).”

A5. We agree.

Q6.

May the medically directing anesthesiologist take a short break to eat a meal or use the rest room?

A6.

Yes, as long as the medically directing anesthesiologist provides frequent monitoring and remains immediately available.

Q7.

If one medically directed case ends at 10:01AM and another begins at 10:01AM, do you consider these cases to be concurrent for medical direction purposes?

A7.

Yes, we do consider these cases to be concurrent.

Q8.

When one member of a group practice starts a case and then another member of the same group assumes medical direction during the case for the remainder of that case (the intra-operative handoff”), how should this case be billed?

A8.

Claims for anesthesia services involving a “hand off” are not specifically addressed by CMS. Until such time when a specific CMS instruction is issued, claims may be submitted to PalmettoGBA in the name of either the provider who starts or finishes the case, or in the name of the individual involved with the service for the longest time

Q9.

A medically directing anesthesiologist is directing 2-4 anesthetists employed by the group. At the end of the day, when only one room remains under way, the medically directing anesthesiologist relieves the one remaining anesthetist and finishes the case personally. Should the case be billed as medically directed, personally performed, or split bill between the two?

A9.

The case cannot be billed as personally performed unless the entire case is performed by the anesthesiologist (exception in question10). We feel the case should be billed a medical direction.

Q10.

In a case in which an anesthesiologist is personally performing the anesthesia services and the anesthesiologist is relieved by a nurse anesthetist for a lunch break, how should the case be billed?

A10.

The current modifiers do not accurately reflect the above situation. We believe the personal performance modifier is the most accurate in the above circumstance. When personal performance is broken for a brief period of time for personal privileges the case should still be billed as personal performance. This only applies to personal privileges and only for brief periods during a case.

Q11.

An epidural catheter is placed for post-operative analgesia. One member of a group places the catheter, and two additional members of the same group make daily visits

(Code 01996) over the next two days. Should each separate visit indicate the name of the physician involved, or may the entire bill for placement and follow up days be billed in one name?

A11.

Each of the days of daily pain management should be submitted under the group name, identifying the physician who actually performed each service.

Q12.

In the event that an anesthesiologist is medically directing one to four concurrent cases and, due to some intervening factor occurring, the medically directing anesthesiologist is unable to be present at emergence, is not immediately available for some portion of the case, or fails to note periodic monitoring on the chart, is it permissible to bill the case as "QZ" as if the services were provided by a non-medically directed CRNA or AA?

A12.

The services of the anesthetist in question should be billed as QZ even though the anesthesiologist provided some level of supervision. However, the frequency of this should be low. In Q5 the definition of emergence describes a process not one point in time. Using this definition most medically directing anesthesiologists will be able to personally participate in this process.

Q13. When should the case be billed as medically supervised (AD) by an anesthesiologist?

A13. Cases are deemed medically supervised when the anesthesiologist is involved in more than four concurrent procedures. All five plus cases would be deemed medically supervised. In some instances the inability to satisfy all medical direction criteria may qualify the case as medical supervision.

Q14.

Can an anesthesiologist bill separately for both a CVP line and a Swan-Ganz catheter in the same heart case if each is used for a different purpose?

A14.

Assuming that the Swan-Ganz catheter is used for cardiac monitoring and the CVP line is placed for a patient with difficult IV access that is documented on the medical record, we would pay for both procedures.

NOTE: 2 distinct catheters are assumed not a Swan-Ganz counted as both a CVP and A Swan.

Q15.

In a previous answer, it was stated that in the situation where one anesthesiologist starts a case and then is relieved by another anesthesiologist in the same practice, the case may be billed in the name of the anesthesiologist who spends the greatest amount of time on

the case. Now assume that an anesthesiologist is medically directing four cases and is called upon to start a fifth case, but is relieved by his partner shortly after the fifth case begins. Can the fifth case be billed in the name of the partner and still allow the first anesthesiologist to bill for medical direction of the other four cases, since his partner relieved him for the majority of the fifth case?

A15.

No, the situation as described would not allow for billing of medical direction by the first anesthesiologist. The assumption of the fifth case, no matter how brief, would violate the rules for medical direction. Indeed, the definition of the code for medical supervision (AD) notes that supervision, not medical direction, occurs when more than four concurrent anesthetic procedures are under the direction of one anesthesiologist. While we would agree with the performance of a number of other duties (as noted above) while medically directing, the assumption of a fifth room would cause all of the five cases to become medically supervised.

Q16.

If an anesthesiologist spends ten minutes continuously with a patient in the holding area administering sedative, leaves to set up the OR, and then resumes continuous care in the OR, may he/she bill for the ten minutes in the holding area?

A16.

Billing for discontinuous time as discussed is allowable, as long as the time billed reflects only the time that a member of the anesthesiology care team (MD, CRNA, or PA) is in actual attendance with the patient. This should be well documented in the medical record.