utmb Health

Billing Compliance Plan: Documentation and Verification of the Anesthetic Care

8th edition

Department of Anesthesiology
University of Texas Medical Branch
Galveston, Texas

Revised August 2024

TABLE OF CONTENTS

Page Number

I. Introduction 2
II. Fraud and Abuse, False Claims Statutes 3
III. Documentation of Anesthesia Care 4
IV. Care Provided for Surgeries and Other Procedures 5
   A. Medical Direction and Other Ways for Anesthesiologists to Bill "Surgical" Anesthesia 5
   B. Medical Direction – Clarification of Requirements 6
   C. Procedures done often with Anesthesia care 11
   D. EPIC Attestations Within the Anesthesia Record 13
V. Care Provided in the Labor and Delivery Suite 15
VI. Care Provided in the Surgical Intensive Care Unit 16
VII. Care Provided by Pain Medicine Services 17
VIII. Enforcement of Compliance Plan 18
IX. Reporting of Possible Problems with Compliance 19

INTRODUCTION

This billing compliance plan's purpose is to describe our process to ensure that we meet the documentation standards of third party payers for professional fee bills submitted and to avoid any false claims or statements associated with billing. The plan focuses on professional charges associated with anesthesia care to patients by the UTMB Department of Anesthesiology clinicians.

The core principle of our billing practice is that before a bill to a payer is submitted, documentation meeting all payer billing requirements is completed and verified. Because knowledge of every payer's requirements is unmanageable while documenting and verifying documentation, we have chosen not to try to individualize the documentation for each payer. Instead, our goal is to meet the documentation requirements of the Medicare program regardless of the patient's actual third-party payer for all patients except women receiving obstetrical anesthesia care. In the Labor and Delivery setting, few if any patients have Medicare, and hence, our goal is to meet the documentation requirements of the Medicaid program of the State of Texas.

This plan is an adjunct to the institutional compliance plan. For E&M services, this plan defers to the institutional compliance plan.

FRAUD AND ABUSE, FALSE CLAIMS STATUTES

A complete presentation on fraud and abuse, or false claims is beyond this document, below are some highlights of the law as pertains to Centers of Medicare and Medicaid Services (CMS).

- The definition of fraud is the intentional deception or misrepresentation that an individual makes and knows to be false or does not believe to be true, knowing that the deception could result in some unauthorized benefit to himself/herself or some other person. "Abuse" is a lesser offense that refers to incidents and practices that are inconsistent with accepted medical practice and result in unnecessary cost or financial loss, directly or indirectly to the Medicare program.
- False claims occur when charges are submitted for services in which not all requirements of documentation are completed. In other words, submitting a bill that does not comply with each requirement established by the payer -- Medicare, other federal government program, or private third party payer -- could lead to liability for false-claims statutes.
- In Fraud and Abuse and False Claims, both civil and criminal penalties can be sought. In general, civil penalties are assessed, because "knowing intent" does not need to be proven. Civil Monetary Penalties law provides for civil monetary penalties of $5,000 to $11,000 for each false claim filed, plus triple damages. Further exclusion from participation in the Medicare and Medicaid programs may be a more financially devastating penalty that may be imposed, because few physicians can financially survive without these patients.
- If it is not legally documented, then it is assumed that it has not been done.
- It is no defense to assert that you or your group did not know the payer billing requirements or did not know what your billing office was submitting under your provider number.
- If a billing office member or other personnel knowingly submits a false claim, then that person is also liable.

DOCUMENTATION OF ANESTHESIA CARE

Anesthesiologists must document their work to meet several different documentation requirements for their anesthesia care. In addition to professional billing (i.e., payment for their professional services) discussed in this plan, anesthesiologists must meet requirements for hospital documentation (prescribed by Joint Commission, CMS, and other hospital accrediting entities), quality measurements of both physicians and hospitals, and good medical care (medical liability). Understanding all the different requirements and completing documentation are essential for a successful professional career.

It is important to note that an anesthesiologist can meet all the documentation requirements to submit a professional charge even when other requirements are not documented. The EPIC notewriter templates and attestations are designed to allow the anesthesiologist to document his/her care as well as include all necessary information needed for hospital documentation.

The following requirements are some examples of non-professional billing requirements:

- CMS Conditions of Participation for Hospitals, Interpretive Guidelines
  - Pre-anesthesia evaluation must be done within 48 hours prior to the time of induction. Required elements of the evaluation are also specified.
  - Intraoperative record elements are specified.
  - Post-anesthesia evaluation must be done within 48 hours after the end of the anesthesia care. Again, elements of the evaluation are specified, must be "clearly documented" and include the following:
    - Respiratory function, including respiratory rate, airway patency, and oxygen saturation;
    - Cardiovascular function, including pulse rate and blood pressure;
    - Mental status;
    - Temperature;
    - Pain;
    - Nausea and vomiting; and
    - Post-operative hydration.

    Except in cases where post-anesthesia sedation is necessary for the optimum medical care of the patient (e.g., ICU) or in pediatric patients, the evaluation may be done any time after the patient is sufficiently recovered from the acute administration of the anesthesia so as to participate in the evaluation.

- Texas Administrative Code 25:1:133:C requires the Post-anesthesia evaluation for outpatients to be done prior to leaving the PACU, but allows for 48 hours for inpatients.

- Joint Commission Hospital Accreditation. In addition to the CMS guidelines listed above (Joint Commission follows), there are many standards involving different aspects of the patient care, including medication management and evaluation. The following is one example of documentation:
  - Joint Commission standards require that "the patient is reevaluated immediately before moderate or deep sedation use and before anesthesia induction". The word immediately would mean when the patient is on the procedure table, in the moments before the sedation is to be administered.

Care Provided for Surgeries and Other Procedures

Goal

Our goal is to meet the documentation requirements of the Medicare program regardless of the patient's actual third party payer for all patients. Note: Since September 2008, the documentation requirements for Texas Medicaid program are functionally the same as the Medicare program.

Audience

The guidelines and documentation requirements are presented to all anesthesia clinicians (faculty anesthesiologists, nurse anesthetists (CRNAs), anesthesiology residents, anesthesia assistants (CAAs), and clinical fellows).

Medical Direction and Other Ways for Anesthesiologists to Bill "Surgical" Anesthesia

Medicare regulations recognize that an anesthesiologist may either

1. Personally Perform the anesthesia service.
2. Medically Direct between 1 and 4 concurrent anesthesia procedures involving qualified anesthesia personnel (resident, CRNA, CAA).
3. Medically Supervise anesthesia involving more than 4 concurrent cases.

Personally Perform

In personally performed cases, the anesthesiologist must be continuously and personally present throughout the entire procedure with the patient. The only exception to presence in the operating room is for personal privileges (i.e., visiting the restroom), but not to provide services to another patient. If the anesthesiologist leaves the patient to care for another patient while a CRNA or resident takes care of the original patient, then that anesthesiologist's services cannot be billed for as personally performed, but must be medically supervised or medically directed.

Medically Supervise

The least stringent way an anesthesiologist may bill is for medically supervised care. Medical supervision is billed for when the anesthesiologist is caring for more than 4 concurrent cases or when all of the 7 steps of medical direction are not met.

Medically Direct

Billing for medical direction requires the most documentation. Anesthesiologists may medically direct 1 to 4 concurrent cases involving residents, CRNAs, or CAAs.

Billing for medical direction requires documentation of the anesthesiologist performing ALL of the following 7 services. Compliance with fewer than all 7 of these requirements is not sufficient to correctly bill for medical direction. As noted above, if documentation does not exist for the work performed, then the assumption by all third party payers, including CMS, is that the work was not done. The 7 requirements are that the anesthesiologist:

1. Performs a preanesthetic examination and evaluation;
2. Prescribes the anesthesia plan;
3. Personally participates in most demanding procedures of the anesthesia plan, including induction and emergence, where applicable;
4. Ensures that any procedure in the anesthetic plan that the anesthesiologist does not personally perform is performed by a qualified anesthesia provider;
5. Monitors the course of anesthesia administration at frequent intervals;

6. Remains physically present and available for immediate diagnosis and treatment of emergencies; and
7. Provides indicated postanesthetic care.

Exceptions to Medical Direction Requirements

Finally, there are exceptions to medical direction requirements. The anesthesiologist may not care for any other patient that they are not currently medically directing except for the following cases:

1. To address an emergency of short duration in the immediate area;
2. To administer an epidural anesthesia to a patient in labor;
3. To perform periodic, not continuous, monitoring of an obstetrical patient;
4. To receive patients entering the operating suite for the next surgery;
5. To check on and discharge patients in the postanesthesia care unit (PACU); or
6. To coordinate scheduling matters.

As a reference for the faculty anesthesiologist, the attestations available in the Anesthesia Record are listed in one table at the end of this chapter.

Medical Direction – Clarification of Requirements

Group Practice of Anesthesiology

CMS recognizes the group practice of anesthesiology. It is not necessary for the same anesthesiologist to perform all 7 requirements of medical direction. One anesthesiologist may do pre-anesthetic examination evaluation, prescribe the anesthetic plan and induce anesthesia, while another anesthesiologist can medically direct the rest of the case. (A "transfer of care" note should be documented in the anesthesia record.) In addition, another anesthesiologist may do the PACU or the post-anesthesia care evaluation.

What is General Anesthesia?

To clarify the issue of when anesthesia care is general anesthesia, the ASA adopted the following definition:

> "If the patient loses consciousness and the ability to respond purposefully, the anesthesia care is a general anesthetic, irrespective of whether airway instrumentation is required."

General anesthesia is differentiated from moderate and deep sedation. General anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Total Intravenous Anesthesia (TIVA) is General Anesthesia

With the above definition, general anesthesia can be provided without the placement of endotracheal tube, LMA or use of inhalational anesthetic. Therefore, when providing care utilizing IV medications/infustions such as propofol or ketamine and the goal is for the patient to be non-responsive, the documentation should reflect that this is general anesthesia using TIVA.

Monitored Anesthesia Care (MAC)

MAC cases are those in which an anesthesiologist is required to monitor a patient due to a co-morbidity that would make monitoring sedation by the performing surgeon an unwarranted health risk to the patient. There is no requirement that any sedation be administered by the anesthesiologist.

For MAC cases, all seven requirements of medical direction must also be met. Many times the actual anesthesia care provided for MAC is not demanding per se. Instead, the co-morbidity of the patient, e.g. severe anxiety or complex medical condition, or the potential for need of interventions, e.g., general anesthesia, may necessitate monitored anesthesia care (MAC). Therefore, there may not be a definable "demanding periods, including induction or emergence" for the MAC. The faculty is still expected to document monitoring of the intraoperative course of anesthesia care. Therefore, as a minimum, the faculty should document a pre-anesthesia evaluation and plan, a note at the start of anesthesia care (see below about induction), intraoperative note if indicated, and post-anesthesia note (for professional billing – document all indicated care was provided; for hospital documentation – a post-anesthesia evaluation).

"Induction Issues"

Present for Induction.
For most general anesthesia and regional anesthesia cases, the induction of anesthesia is a discreet short period of time. When the faculty uses the "Induction" attestation within the EPIC anesthesia record, this is sufficient to meet this requirement since the attestation will be time-associated with events in the anesthesia record. The anesthesia record will have the details of the induction.

General Anesthesia via GANA (GA no Airway) with TIVA:
For GANA using TIVA, the induction of TIVA is often not a short discreet period of time and not a demanding portion of the care. When the faculty documents present for induction for TIVA case, the phrase "present for induction" reflects the faculty was present for the start of induction of TIVA. Hence, "Induction" attestation within the EPIC anesthesia record is sufficient for the documentation of this service.

Induction of Regional Anesthesia:
The faculty anesthesiologist who is present for the placement of the block is responsible for both the pre-anesthesia evaluation and the induction note (attestation "Induction"). In a case where the regional faculty transfers care to the OR faculty, the OR faculty will document acceptance of the care and document that they were present for the start of OR care by using the attestation "OR Start after Regional Anesthesia". On the other hand, if the regional faculty is the OR faculty, no further notes needed (example: spinal anesthesia for Cesarean section.)

Monitored Anesthesia Care (MAC):
Because induction of MAC is not a demanding portion of anesthesia care, no present for induction note is required. On the other hand, the faculty is expected to be present for the beginning of care (includes the time out and the reevaluation of the patient immediately prior to start). We have chosen to include this documentation in an induction note attestation named "Induction MAC" within the EPIC anesthesia record.

"Emergence" Issues

Because the requirement "Personally participates in most demanding procedures of the anesthesia plan, including induction and emergence, where applicable" has the qualifier of "where applicable", then emergence note is not required for all care – only when emergence is a demanding portion of the care.

For MAC cases:
Since emergence is not a demanding portion of most MAC cases, no emergence note is needed. For the EPIC anesthesia record, faculty anesthesiologist should document this by using the attestation "Emergence not needed".

For Regional Anesthesia:

A faculty anesthesiologist must document his/her presence during the induction/placement of the regional anesthesia block (using "Induction" attestation), but no emergence note is necessary if not applicable. (One regional technique that it may be applicable to have an emergence note is IV Regional or Bier Block.) For the EPIC anesthesia record, faculty anesthesiologist should document this by using the attestation "Emergence not needed".

For General Anesthesia:
For the majority of general anesthesia cases, the emergence period is a demanding portion of the anesthetics. But in specific cases, it is not. Examples where an emergence note IS NOT necessary include, but not limited to, TIVA cases where no airway appliance is placed, and cases where the patient is transported from the OR to PACU or ICU while still intubated. In almost all other cases, an emergence note is indicated.

Further, unlike induction of general anesthesia, the emergence from general anesthesia is not a discrete point in time, but occurs over a longer period of time. Emergence is not simply extubation. Emergence from general anesthesia can be reasonably viewed as beginning when the decision to decrease the level of anesthesia begins. In some cases, this may be 20 - 30 minutes before the end of surgery. Emergence continues through the lightening of the patient's anesthetic and extubation but does not end at that point. It continues in the recovery room and ends when the patient is awake, oriented, and ready to be discharged from the PACU. Therefore, we define *emergence from general anesthesia as occurring from the time the anesthesia is lightened to the time the patient is awake and oriented.*

CMS has not defined the emergence period, but the definition that emergence period starts in the OR and ends sometime in the PACU is supported by the CMS Conditions of Participation Interpretive Guidelines where the post-anesthesia assessment should not be typically done at the time of admission to the PACU. Further, a 2015 finding in federal legal case found that this definition is reasonable under current CMS regulations.

Hence, *we have defined that an anesthesiologist is "present for emergence" if he/she fulfills the following criteria*:

- Physically present and available for immediate diagnosis and treatment of emergencies (same as medical direction requirements);
- Medically directs the emergence, i.e., the anesthesiologist is involved in the medical direction decision of how emergence will be handled;
- Is "face-to-face" with the patient at some time during the emergence period.

The faculty anesthesiologist uses the "Emergence" attestation within the EPIC anesthesia record and should "time the event" to when the anesthesiologist was face-to-face with the patient during emergence.

Documentation of monitoring the course of anesthesia administration at frequent intervals.

As seen above, one of the requirements of medical direction is that the faculty anesthesiologist "monitors the course of anesthesia administration." For documentation of this activity, the faculty anesthesiologist should enter into EPIC anesthesia record the attestation "Intraoperative Monitoring".

There is no minimum standard of how often this should be done, because the medical necessity of the monitoring is dependent on many factors, including surgical procedure, ASA classification, age, and experience of anesthesia clinician.

Definition of "Immediately available"

The number 6 requirement for medical direction is "Remains physically present and available for immediate diagnosis and treatment of emergencies;"

The ASA defines this term in the following way:

> **A medically directing anesthesiologist is immediately available if s/he is in physical proximity that allows the anesthesiologist to return to re-establish direct contact with the patient to meet medical needs and address any urgent or emergent clinical problems. These responsibilities may also be met through coordination among anesthesiologists of the same group or department.**
>
> **Differences in the design and size of various facilities make it impossible to define a universally applicable specific time or distance for physical proximity.**

"Coordination among anesthesiologists":
CMS recognizes the group practice of anesthesiology, meaning that not all the requirements for medical direction must be met by one anesthesiologist, but must be met by additional anesthesiologists. In non-emergent situations, transfer of care needs to be documented by at least an acceptance note.

"Makes it impossible to define a universally applicable specific time or distance for physical proximity":
Although it is very difficult to define a minimum physical distance because this will vary based on multiple medical factors, the UTMB Department of Anesthesiology has defined a maximum distance from the Operating Room suite, that is entitled "Perioperative Area". If a faculty anesthesiologist must leave the Area, then he/she is considered not "immediately available" and cannot be medical directing an anesthesia case in the Area. In the rare emergency situation, faculty should communicate directly with another faculty who will cover and then document after the fact to identify to whom the care was transferred. In non-emergent cases, communication and documentation should be done prior to leaving the Area.

UTMB Perioperative Area at John Sealy Hospital Galveston Campus

The area is defined in both "vertical" and "horizontal" hallways. For vertical hallways, the sites must be within 2 floors. For horizontal definition for John Sealy, the area's outer limits are from 2nd floor Radiology Suite, 4th floor GI endscopy suite to 3rd floor Labor and Delivery.

UTMB Perioperative Area at Jennie Sealy Hospital Galveston Campus

The area is defined in both "vertical" and "horizontal" hallways centering around the Operating Rooms on the 4th floor. (Note: There is no 3rd floor, and the 2nd floor/Main Lobby is only one floor below). For vertical hallways, the sites must be within 2 floors. The horizontal definition for Jennie Sealy is the length of the ORs on 4th floor and TDCJ holding/PACU in adjacent hallway. With these definitions, the DSU, APAC units on 2nd floor, Cath Lab on 6th floor, and the offices and break rooms on 5th floor are within the area.

UTMB Perioperative Area at Clear Lake Campus

The area is defined in both "vertical" and "horizontal" hallways centering around the Operating Room on the 3rd floor. For vertical hallways, the sites must be within 2 floors. With this definition, the perioperative area includes Radiology and ED on the 1st floor, Cath Lab on the 2nd floor, and Labor and Delivery on the 5th floor.

UTMB Perioperative Area at Angleton Danbury Campus

The area is defined in both "vertical" and "horizontal" hallways. The facility has anesthesia sites on two adjacent floors (Operating Rooms and an Endoscopy Suite are on the 1st floor, with Labor and Delivery on the 2nd floor). Horizontal hallways connect all locations.

Providing Breaks and Immediately Available.

A faculty is considered immediately available when giving a break when the following requirements are met:

- There must be another faculty available in the Perioperative Area to respond to "Anesthesia Stat" call.
- The clinician being given the break must stay in the Perioperative Area and be able to return when contacted by either cell phone or pager.

Post-anesthesia Evaluation

For the purpose of professional billing, the faculty must document that "indicated post-anesthesia care was provided". This evaluation is usually done in the PACU, and may be done by a different anesthesiologist from the anesthesiologist who directed the OR care. For patients who do not stop in the PACU, i.e., ICU transfers or, cases returning to the holding area post-operatively, it is the OR anesthesiologist's responsibility to complete the post-anesthesia note.

- In situations where the patient has been discharged and no evaluation was done prior to discharge, it is still possible to meet the physician billing requirements. Because an anesthesiology faculty is available 24/7 in the hospital and provides or can provide any indicated care on a patient in the PACU, DSU or other hospital unit, the provision/requirement to provide the indicated post anesthetic care is met. To document this requirement, the anesthesiology faculty who provided end of the anesthesia care should review the PACU medical record and determine if indicated post-anesthesia care was provided. If so, the faculty should document in EPIC Post-anesthesia Evaluation Note, the following, (1) Evaluation done – note was done by review of PACU or medical record, (2) Patient did not participate, and (3) at the comment section, note that all indicated post-anesthesia care was provided. The faculty who completed the case will be responsible for this note.

Qualified Anesthesia Provider

Requirement #4 - Ensure that any procedure in the anesthetic plan that the anesthesiologist does not perform is performed by a qualified provider. Qualified Provider is defined by CMS's Conditions of Participation: Anesthesia [CFR §482.52(a)]. "Anesthesia must be administered only by" (1) an anesthesiologist, (2) a physician (other than an anesthesiologist), (3) a dentist or oral surgeon, (4) a nurse anesthetist, and (5) an anesthesiologist assistant. The anesthesia staffing is documented in the staffing grid of the anesthesia record.

Documentation of Transfer of Care

Considering that CMS recognizes the group practice of anesthesiology, if the first anesthesiologist is relieved, the transfer must be documented and timed. It is required to document the time of acceptance of care and availability by the new anesthesiologist. At a minimum, an accept attestation is required by the new anesthesiologist. Faculty anesthesiologists should use the "Transfer care" and "Accept care" attestations in the EPIC anesthesia record as well as change the staff assignments in the anesthesia record.

Documentation of Start and Finish Times

Start time and finish time ARE NOT in-room and out-of-room times nor is it surgery start and stop times.

Start Time is the time when the anesthesia clinician begins providing anesthesia care. This occurs after the pre-anesthesia evaluation is complete. If the patient is left unattended, then by definition anesthesia care is not being provided. In addition, the start time may be before the faculty is present, but when the resident, CRNA, or CAA begins care. Examples: (1) the anesthesia clinician must transport patient from ICU – Start time begins when pre-anesthesia evaluation finishes and the clinician begins continuous care, hence it begins in the ICU; (2) after the pre-anesthesia evaluation is completed, and the anesthesia clinician places IV in holding and then immediately transports to OR – Start time begins when IV placed; and (3) patient and the anesthesia clinician enter OR at 7:15 AM, but the pre-anesthesia evaluation has not been completed. Resident does pre-anesthesia evaluation and finishes at 7:25 AM– Start time begins at 7:25 AM.

The finish time is defined as when the anesthesia clinician (faculty, resident, CRNA, or CAA) has stopped providing continuous care to the patient. This time should be either when the report is complete in the PACU, ICU, or holding (for MAC cases) or care is transferred to another clinician. The finish time is not when the patient leaves the OR. If the finish time is not documented, the last timed note – usually the last vital sign – is used as the finish time. Therefore, it is essential that the finish time be documented accurately to be able to code and bill correctly.

PROCEDURES DONE OFTEN WITH ANESTHESIA CARE

Post-operative Pain Procedures

For additional information, see the ASA "Statement on Reporting Post-operative Pain Procedures in Conjunction with Anesthesia". Placement of epidurals and peripheral nerve blocks for post-operative pain control (post-operative pain procedures) is separate and distinct from surgical anesthesia services. Valuations for anesthetic codes do not include the work of performing post-operative pain procedures and payment for them should not be bundled with that of the anesthetic service. These post-operative pain procedures may be reported in conjunction with an anesthesia service when certain specific conditions are met. A key consideration is clear recognition of the difference between regional anesthesia that is performed as the primary surgical anesthetic as opposed to post-operative pain procedures which are intended primarily to provide post-operative analgesia. Post-operative pain procedures performed primarily for post-operative analgesia may be separately reported whether they are administered pre-operatively, intra-operatively or post-operatively.

There should be documentation that the surgeon supports the patient receiving the post-operative pain procedure. This can be done by a separate note by the surgeon. If the procedure is done after induction, by noting the block in the operative note, the surgeon is documenting they were aware and waited for the block to be completed.

A post-operative pain procedure may be reported as a service separate from the anesthetic if the post-operative pain procedure is employed primarily for post-operative analgesia and if the following conditions apply:

1. The anesthesia for the surgical procedure was not dependent upon the efficacy of the post-operative pain procedure.
2. The time spent on pre- or post-operative placement of a block is separated and not included in reported anesthetic time.
3. Time for post-operative pain procedure that occurs after induction and prior to emergence does not need to be deducted from reported anesthesia time.
4. Time for a post-operative pain procedure that occurs after Anesthesia Start time and prior to anesthesia induction should be deducted from reported anesthesia time.

Further, it should be noted that it is not acceptable to bill a MAC case with a post-operative pain block. By definition, the block is the primary anesthetic and the case should be billed as a regional anesthesia case (and the sedation is part of the anesthesia care).

Regional Anesthesia and Responsibility of Pre-anesthesia Evaluation and Induction Note

In cases of regional anesthesia done with the block done in the block room, the faculty in the block room and the faculty in the operating room are both responsible for the documentation. Although both the block faculty and the OR faculty should have performed a pre-anesthesia evaluation to determine that regional anesthesia is appropriate and developed the plan for regional anesthesia, only one faculty must document the pre-anesthesia evaluation and plan. When this documentation is incomplete**, the "block faculty" has been arbitrarily identified as the faculty who will be paged to complete this documentation**. The "block faculty" who was present for the induction of the regional block should complete the induction note. The

"block faculty" needs to document the transfer of care. The OR faculty must document acceptance of care and availability as indicated in the required "Documentation of Transfer of Care" as indicated above and that the block is working.

Transesophageal Echocardiography

For additional information, see the ASA "Statement on Transesophageal Echocardiography".
The indication of transesophageal echocardiography (TEE) is generally based on the individual's medical condition rather than the surgical procedure. Because of this, the work value and practice expense of TEE services are not included in the base unit values for anesthesia services and is a separable billable service.

"Basic Perioperative TEE" refers to the medical practice of performing TEE for image and data acquisition by a physician who intends to use the information primarily for monitoring the patient. "Advanced Perioperative TEE" refers to the medical practice of performing TEE for image and data acquisition by a physician who intends to utilize the full diagnostic potential of perioperative TEE, including the interpretation of the data for perioperative surgical decision-making.

For advanced perioperative TEE services, faculty documentation must include presence and supervision of a resident or fellow if not done personally by the faculty for the service that includes probe placement, image acquisition, interpretation and report. See the ASA Statement for additional details including description of the services.

Intravascular catheterization procedures placement

For additional information, see the ASA "Statement on Intravascular Catheterization Procedures".
Some patients undergoing anesthesia require more precise and sophisticated level of cardiovascular monitoring than the standard non-invasive techniques. In addition, some patients undergoing anesthesia benefit by having additional venous access than a peripheral intravenous catheter. Because not all patients undergoing a surgical procedure require the advanced catheters, the placement of these catheters is not included in the base value of the anesthesia services. Therefore, placement of arterial line, central venous catheter and/or flow directed pulmonary artery catheter is a separable billable service. On the other hand interpretation of the data obtained from these "invasive" catheters is considered part of the anesthesia service.

Faculty documentation must include presence for key portions if placed by resident or fellow, if not placed personally by the faculty.

VERIFICATION AND CHARGE SUBMISSION

The Department of Anesthesiology follows the UTMB Physician Practice Plan policies about completion of documentation prior to submission of charges. Physicians will receive notification of incomplete documentation via email and have 48 hours to complete or respond. Incomplete documentation reports will be sent periodically to the Chair.

EPIC Attestations Within the Anesthesia Record

Tab Name	Text	Comment box used for …
Induction	Immediately prior to induction of anesthesia, I reevaluated the patient and there was no change from the pre-operative anesthesia evaluation. I was present for induction. I am immediately available and directed medical care.	
Induction MAC	Immediately prior to induction of anesthesia, I reevaluated the patient and there was no change from the pre-operative anesthesia evaluation. I was present for start of MAC care. I am immediately available and directed medical care.	
Induction Entire	Immediately prior to induction of anesthesia, I reevaluated the patient and there was no change from the pre-operative anesthesia evaluation. I am present for the entire case.	
Induction AC	Immediately prior to induction of anesthesia, I reevaluated the patient and there was no change from the pre-operative anesthesia evaluation. I was present for induction. After giving report, I transferred care to below physician. (see comment box for name and time)	[Specify name], [Specify time]
OR Start after Regional Block	Prior to start of OR anesthesia care, I re-evaluated the patient and there was no interval change. I was present for timeout and start of OR anesthesia care. I was available throughout and directed medical care.	
Emergence Not Needed	Emergence note is not needed since emergence is not a demanding portion of the anesthesia care	
Emergence	I was present for emergence.	
Procedure	I was present for procedure (see comments for details)	[specify the procedure] [specify if details in another note]
Postop pain block	I was present for the post-operative pain block. Location of surgeon request noted below	[specify location]
Transfer Care	After full report, I transferred care to below physician. (see comment box for name and time)	[Specify name], [Specify time]
Accept Care	After full report, I accepted care at below specified time. I am immediately available and directed medical care from that time.	[specify time]

Tab Name	Text	Comment box used for …
Intraoperative Monitoring	At bedside, I reviewed the progress of the procedure and the anesthetic management.	
Intraoperative Event	I was present for (specify in comments)	[free text of event]
Transport to ICU	I was present for transport of patient to ICU.	
LEA Present	Labor epidural analgesia placed, see anesthesia record for additional details. I was present during epidural placement. Patient comfortable and VSS after placement.	
LEA Immediately Available	Labor epidural analgesia placed, see anesthesia record for additional details. I was immediately available during epidural placement. Patient comfortable and VSS after placement.	

Note: Additional attestations may be "built" and will be added during revisions.

CARE PROVIDED IN LABOR AND DELIVERY SUITE

GOAL

In contrast to the other areas where anesthesia care is given, in the Labor and Delivery (L&D) setting, few if any patients have Medicare, and hence, our goal is to meet the documentation requirements of the Medicaid program of the State of Texas.

SUPERVISION FOR LABOR EPIDURALS

Although Texas Medicaid utilizes similar documentation rules for surgical anesthesia as does Medicare, Medicaid recognizes labor epidural analgesia as an exception to medical direction. In this case, Medicaid rules recognize supervision. For the typical parturient, the faculty anesthesiologist must provide direct supervision of residents and fellows for labor epidural placement and management. Direct supervision requires the faculty to be in the facility and immediately available to furnish assistance and direction as needed. In addition, the teaching physician supervision in an inpatient setting, the following needs to be documented:

1. Reviewing the patient's history and physical examination and personally examining the patient within a reasonable period after the patient's admission and before the patient's discharge.
2. Confirming or revising the patient's diagnosis.
3. Determining the course of treatment to be followed.
4. Ensuring that any supervision needed by the interns or residents is provided.
5. A face-to-face encounter with the patient on the same day as any services provided by the resident physician.

Faculty anesthesiologist can meet the criteria listed above by the following notes.

- Criteria #1,2: Pre-anesthesia note
- Criteria #3,4,5: Intraoperative note (EPIC Attestation within the record: LEA Present or LEA Immediately Available)
- Post-anesthesia evaluation: although not specified for teaching physician, for anesthesia care, it is required for all patients.

ALL OTHER ANESTHESIA SERVICES

For all other services other than labor epidural, the documentation and billing is done similarly to surgical anesthesia and procedures as noted in the previous chapter.

VERIFICATION AND CHARGE SUBMISSION

The Department of Anesthesiology follows the UTMB Physician Practice Plan policies about completion of documentation prior to submission of charges. Physicians will receive notification of incomplete documentation via email and have 48 hours to complete or respond. Incomplete documentation reports will be sent periodically to the Chair.

CARE PROVIDED IN THE SURGICAL INTENSIVE CARE UNIT (SICU)

GOAL
Our goal is to meet the documentation requirements of the Medicare program regardless of the patient's actual third party payer for all patients.

AUDIENCE
Because only members of the division of Intensive Care are involved in providing care and submitting charges, compliance education program for intensive care unit billing and documentation is focused on these faculty as well as billing personnel.

GUIDELINES FOR DOCUMENTATION
Coding and billing meet Medicare guidelines for all services. For guidelines and documentation requirements, please refer to the Faculty Group Practice Financial Services Guidelines, the Billing Compliance Plan (IHOP Policy 06.03.01), and the Clinical Billing, Documentation, and Coding Policy (IHOP Policy 06.03.00).

VERIFICATION AND CHARGE SUBMISSION
The Department of Anesthesiology follows the UTMB Physician Practice Plan policies about completion of documentation prior to submission of charges. Physicians will receive notification of incomplete documentation via email and have 48 hours to complete or respond. Incomplete documentation reports will be sent periodically to the Chair.

CARE PROVIDED BY THE PAIN MEDICINE SERVICES

GOAL

Our goal is to meet the documentation requirements of the Medicare program regardless of the patient's actual third party payer for all patients

AUDIENCE

Because only members of the division of Pain Medicine Service are involved in providing care and submitting charges, compliance education program for outpatient evaluation and management and in-patient consult billing and documentation is focused on these faculty as well as billing personnel.

GUIDELINES FOR DOCUMENTATION

Coding and billing meet Medicare guidelines for all services. For guidelines and documentation requirements, please refer to the Faculty Group Practice Financial Services Guidelines, the Billing Compliance Plan (IHOP Policy 06.03.01), and the Clinical Billing, Documentation and Coding Policy (IHOP Policy 06.03.00).

MEDICAL DIRECTION OF ANESTHESIA CARE AND PAIN MEDICINE SERVICES

As noted in chapter discussing care provided in the operating room, while medically directing care, an attending anesthesiologist can only provide care to the patients who are receiving anesthesia care that he/she is medical directing. The only exceptions to this requirement are listed in that section. Pain Medicine services and procedures are not listed in the exceptions. Therefore, if a pain medicine faculty is providing medical direction for anesthesia care, that **pain medicine faculty can only provide pain management care if they transfer care to another anesthesiologist**. Accurate documentation of these activities requires timing of all notes, including transfer of care notes.

VERIFICATION AND CHARGE SUBMISSION

The Department of Anesthesiology follows the UTMB Physician Practice Plan policies about completion of documentation prior to submission of charges. Physicians will receive notification of incomplete documentation via email and have 48 hours to complete or respond. Incomplete documentation reports will be sent periodically to the Chair.

ENFORCEMENT OF THE COMPLIANCE PLAN

As noted in the preface, if documentation does not support a charge, then the payer is not billed for the services rendered.

REVIEWS FOR COMPLIANCE

Periodic and random pre-billing (before a charge is submitted) reviews may be performed in order to assure accuracy of coding and verification of appropriate documentation. Post-billing (after charges submitted) reviews are only conducted under the direction of the Office of Institutional Compliance (OIC).

NONCOMPLIANCE

Clinical members of the department

If a specific person is identified as failing to comply with this plan, resulting in consistent non-billing or inappropriate billing, they will be referred to the Office of Institutional Compliance (OIC) for appropriate action, and then, if necessary, counseled by the Chair of the Anesthesiology Department.

REPORTING OF POSSIBLE PROBLEMS WITH COMPLIANCE

We, as a department, will address all compliance concerns raised by any member of the department may have. We encourage any member to report concerns in the following manner:

1. Any member of the department may report possible compliance concerns to the Departmental Billing Compliance Officer, the Vice Chair of Clinical Affairs, the Department Administrator, or the Department Chair. The identity of those filing reports of noncompliance will remain confidential. Members reporting concerns are encouraged not to be anonymous. Being able to contact the person for more details or for discussions allows the department to resolve any concerns more quickly and accurately.

2. If anyone wishes to raise a concern anonymously, he/she should feel free to do so. In such reports, details including the patient's name, MRN#, date of service, the names of members of the department, and reasons for concern must be specified in order to address the concerns.

3. Finally, if anyone is uncomfortable reporting in the above manner, he/she can report it to the Office of Institutional Compliance, UTMB via the Hotline at 1-800-898-7679.