Billing Compliance Plan: Documentation and Verification of the Anesthetic Care

Fourth Addition

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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 Department of Anesthesiology but does not necessarily include the program at Driscoll's Children's Hospital (Corpus Christi) that has a similar plan.

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.

FRAUD AND ABUSE, FALSE CLAIMS STATUTES

For a more complete discussion of fraud, abuse and false claim statutes, please see the monograph published by the American Society of Anesthesiologists (ASA) entitled "Compliance with Medicare and other Payer Billing Requirements."

Some important notes from this monograph about these statutes are:

- 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 $10,000 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.

CARE PROVIDED IN THE OPERATING ROOM (OR)

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: Beginning September 2008, the documentation requirements for Texas Medicaid program are the same as the Medicare program.

AUDIENCE

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

MEDICAL DIRECTION AND OTHER WAYS FOR ANESTHESIOLOGISTS TO BILL

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, AA).
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 as 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 meet. The reimbursement for medical supervision may be very limited depending on the payer. For teaching anesthesiologists, Centers for Medicare and Medicaid Services (CMS) barely reimburses for medical supervision of residents (total of 4 ASA units no matter what or how long the case).

Medically Direct

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

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;
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 he is 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.

For specific instructions on notes that the physicians can write to meet qualifications of the documentation, please see the section below.

MEDICAL DIRECTION – CLARIFICATION OF REQUIREMENTS

"Emergence" Issues

In the past, the requirement that the anesthesiologist must document his/her "presence for emergence" regardless of the type of anesthesia provided, i.e., general anesthesia, regional anesthesia, or monitored anesthesia care (MAC) has been confusing. With the recent change to include the phrase "where applicable" has helped clarify the emergence issue for documentation. Still, CMS has not defined emergence from general anesthesia, therefore it is necessary we define emergence from general anesthesia (below) based on the existing statutes, regulations, and our medical judgment as guidelines.

For MAC cases: A faculty anesthesiologist must document induction or emergence notes if applicable. One applicable example would be sedation for retrobulbar block, but in this case only one note would be needed.

For Regional Anesthesia: A faculty anesthesiologist must document his/her presence during the placement of the regional anesthesia block, 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 General Anesthesia: A faculty anesthesiologist must document presence during emergence where applicable. In contrast to regional anesthesia situation, presence during emergence must be documented with few exceptions. One exception is the case of an intubated patient being admitted to the intensive care unit. In that case, presence during transport may be more applicable.

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 hospital. 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 recognizes that an anesthesiologist may be "present" with more than one patient at one time, i.e., caring for concurrent patients. The practice of anesthesiology is unique in this characteristic. Because of this concurrence allotment and the long period of emergence, *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 direct 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.

Documentation of monitoring the course of anesthesia administration

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 periodically note on the anesthesia record that he/she has checked on the course of anesthesia care. This documentation may simply "VSS" with time and initials in the bottom of the note section. 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 provider. The department recommendation is for documenting every time the

faculty anesthesiologist enters the OR. As a guideline, this should be done at least once per anesthesia record page.

Postoperative Evaluation

This evaluation is usually done in the PACU, usually by a different anesthesiologist from the anesthesiologist who directed the OR care. This note should go on the back of the first page of the anesthesia record. (See Appendix 2.) 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 postoperative note.

Group Practice for 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 preanesthetic 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 postoperative care evaluation.

Other Requirements of Medical Direction

Requirement #4 - Ensure that any procedure in the anesthetic plan that the anesthesiologist does not perform is performed by a qualified provider: This is a credentialing issue that needs to be taken care of before the caregiver is given clinical privileges. It does not need to be documented on the anesthetic record.

MEDICAL DIRECTION – OTHER ISSUES

What is General Anesthesia?

To clarify the issue of when anesthesia care is general anesthesia, in October 2003, 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."

Total Intravenous Anesthesia (TIVA)

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 propofol, remifentanil, ketamine or a combination* and the goal is for the patient to be non-responsive (especially in remote sites), the documentation should reflect that this is a GA using TIVA.

In these specific types of GA cases, the faculty needs to complete the following documentation:

1. Preoperative evaluation and plan (please include "TIVA" in your plan)
2. Intraoperative note (e.g., "present for start of TIVA" or "present for ongoing TIVA") **place in the Induction Note box
3. Availability note (e.g., "available throughout")
4. Postoperative note (e.g., "awake, VSS, no apparent complications")

- NOTE: Emergence note is not required for TIVA general anesthesia

*These are example of intravenous agents used for general anesthesia. This list is not a complete and all-inclusive list.

Documentation of Medical Direction of a MAC case

MAC cases are those in which an anesthesiologist is required to monitor a patient due to a contradictory 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. A full list of diagnosis that may require an anesthesiologists attendance is available upon request.

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 intraoperative course of anesthesia care. Therefore, as a minimum, the faculty should document at least one time the evaluation of the MAC. For example, "patient comfortable and VSS" and time the note. **For ease of verification of documentation, this note should be placed in the "induction note" area.** If not, the faculty may be paged by the PACU billing coder for incomplete documentation. In this case, the faculty will need to show the coder where the documentation is located.

Postoperative Pain Management Block

Postoperative pain management blocks are billable services, even if done preoperatively or intraoperatively. Our departmental guideline in determining if billable is determining if the block is the primary anesthetic technique or not. If not, then it is a billable procedure. In other words, does the patient undergo the block (and its benefits and risks) for the surgery or for postoperative pain management. If "for the surgery" is part of the answer then it is not a billable service.

Examples of billable blocks: Note: In all cases, one can say that the patient was going to have a general anesthesia with or without the block. Hence, patient underwent the block for postoperative pain management, not anesthesia.

- Interscalene block with general endotracheal anesthesia for shoulder surgery.

- Caudal block with general anesthesia in a child undergoing inguinal hernia repair.
- Epidural catheter placement (and used during the surgery) with general anesthesia for a total abdominal hysterectomy in a relatively healthy woman.

Examples of blocks that are not separately billable procedures. Note: In all the cases, one can say that the primary anesthetic plan includes the block and that the patient underwent the block as part of the anesthesia for the surgery.

- Ankle block for debridement of gangrene foot in a diabetic patient.
- Interscalene block for PTFE placement in the upper extremity in a patient with end stage renal disease
- Epidural catheter for total knee arthoplasty in an elderly man.

Further, it should be noted that it is not acceptable to bill a MAC case with a postoperative 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). In cases where TIVA general anesthesia is performed with a block, our department will not bill out the block separately, because the block was part of the anesthesia plan.

Regional Anesthesia and Responsibility of Preoperative 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 an preoperative evaluation to determine that regional anesthesia is appropriate and developed the plan for regional anesthesia, only one faculty must document the preoperative 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.

Documentation of Transfer of Care

Considering that CMS recognizes the group practice of anesthesiology, if the first anesthesiologist is relieved of medical direction, the transfer must be documented and timed. It is required to document the time of acceptance of care and availability by the new anesthesiologist. Further, it is recommended that the first anesthesiologist times and documents report given and relief accepted.

Documentation of Start and Finish Times

This topic is included as a reminder to all providers. 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 care provider begins providing anesthesia care. This occurs after the preoperative 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 AA begins care. Examples: (1) resident must transport patient from ICU – Start time begins when preoperative evaluation finishes and the resident begins continuous care, hence it begins in the ICU; (2) resident places IV in holding and then immediately transports to OR – Start time begins when IV placed; and (3) patient and resident enter OR at 7:15 AM, but the preoperative evaluation has not been completed. Resident does preoperative evaluation and finishes at 7:25 AM. After IV started, the faculty arrives at 7:35 AM – Start time begins at 7:25 AM.

The finish time is defined as when the anesthesia provider (faculty, resident, CRNA, or AA) has stopped providing continuous care to the patient. This time should be either when report is complete in the PACU, ICU, or holding (for MAC cases) or care is transferred to another provider. 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.

Providing Breaks and Availability

When medically directing, faculty anesthesiologists must remain available for immediate diagnosis and treatment of emergencies. Because the group practice of anesthesiology is recognized, for our group, the minimum standards for this requirement to be met are the following:

- There must be more than one faculty anesthesiologist in the OR suite.
- The faculty anesthesiologist must remain in the immediate area of the OR suite.
- The faculty anesthesiologist must always carry a pager and answer promptly any pages to an operating room.
- When the faculty anesthesiologist gives a break while medical directing, the anesthesia provider on break must be able to return to the OR immediately if needed. The CRNA/AA/resident is required to take their break in the immediate area of the OR suite.

EXAMPLES OF PHYSICIAN DOCUMENTATION FOR MEDICAL DIRECTION

The following are examples of typical anesthesiologists' notes for the variety of requirements for medical direction. We have developed these examples as a guide to our faculty anesthesiologists. We encourage them to individualize the notes for each patient.

Preoperative Evaluation

The anesthesiologist must document that he/she examined the patient and his/her individual assessment. One does not need to repeat a previous evaluation and can note the resident's, CRNA's, AA's, or PA's information, but writing "agree with above" is not sufficient. The anesthesiologist must also document his/her anesthetic care plan. This note is placed at the bottom of the Preanesthesia Anesthesia Evaluation Note in the "Day of Surgery Note" section. (See Appendix 1) Example:

- (for Cholecystectomy) Patient examined. Above noted. 43 yo woman, ASA II for HTN and obesity. Plan GA with ETT.

Intraoperative Presence and Direction

CMS requires documentation of availability throughout the case and presence for critical portions of the anesthesia, including induction and emergence. We document availability next to the signature at the bottom of the anesthesia record with a note, such as "available throughout."

For documenting intraoperative monitoring of the course of anesthesia, the anesthesiologist should note the time and initial to document his/her presence. This may simply be documentation of "VSS" or may be more detailed if a significant event is occurring.

On the anesthesia record, there are spaces available for completion of induction, emergence, and postoperative notes. Additional space is available for notes for other events, e.g., transfer of care, intraoperative monitoring, line placements, or other intraoperative events. These notes should document the anesthesiologist's presence and medical direction, but *should not include the words "supervise" or "supervised"* to avoid confusion. Examples:

Induction-specific notes:

"Present for induction, …

- ...Smooth mask induction, IV placed, intubation without problem"
- ...IV induction, intubation as noted, present for positioning"
- ...Spinal placed at L2-3 without difficulty"

Emergence-specific notes:

"Present for emergence, ...

- ... Awake, extubated"
- ... and extubation"

The medical direction requirement is to provide indicated postanesthetic care. For a patient with an uncomplicated course, this indicated care might simply entail an examination of the patient in a recovery area and note no apparent anesthetic complications. Similarly, if patient is taken to ICU from the OR, the indicated care may be in the report given to ICU team. Example:

- for PACU patient: "Patient examined. Awake. VSS, no apparent complications from anesthesia"
- for ICU patient: "VSS, Report given to ICU Staff"

VERIFICATION AND CHARGE SUBMISSION

In facilities where volume of cases is sufficient, we will verify and submit charges in "real-time". The procedure is as follows. For OR patients, we verify all patients who go through the PACU (Recovery Room) during regular workdays. A qualified individual (coder or coding assistant) from the billing office is stationed in the PACU to verify documentation. If documentation is incomplete, the individual pages and notifies the attending anesthesiologist. If the documentation is still not verified as complete, the attending anesthesiologist is paged the following day as well as an email is sent to the anesthesiologist. Verification is complete when either the billing personnel have reviewed the documentation or the attending anesthesiologist communicates (either by phone or email) that the incomplete documentation has been completed. The verification process is tracked for each individual case on a verification sheet that is maintained with the billing copy of the anesthesia record. (Copy of this form is available on request.)

In facilities where volume of cases does not justify a billing person in the PACU, then the faculty anesthesiologist will have to complete a billing verification sheet to be submitted with the billing copy of the record. On this sheet, the faculty will note which documentation is complete for the procedure. The billing office will use this as a testament that documentation is complete.

A consistent and easy location for the notes is essential to make this verification process efficient. On the preoperative forms, the section entitled "Day of Surgery Note" is used to place the attending anesthesiologist's preoperative note. On the anesthesia record, there are defined places for induction, emergence, and postoperative notes as well as space for additional intraoperative notes. (Copies of these documentation forms are available on request.)

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.

AUDIENCE

Although the majority of time, only members of the obstetric anesthesia division perform the care provided in the L&D setting, the guidelines and documentation requirements is presented to all members of the clinical anesthesia providers (faculty, CRNAs, AAs, and fellows) as well as billing personnel.

PERSONAL 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. In general, for a faculty physician to demonstrate that personable and identifiable direction was provided by following and documenting these five criteria:

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. Documenting in the patient's medical record appropriate daily record of tasks identified above before submitting the claim.

Faculty anesthesiologist can meet the criteria listed above by the following notes. Note: Preoperative, Intraoperative, and Postoperative Notes are completed at the bottom of the front of the OB Anesthesia Record (see Appendix):

- Criteria #1,2: Preoperative note
- Criteria #3,4: Intraoperative note
- Criteria #5: Postoperative note, Verification (below)

For complex and dangerous situations, including critical events during surgery and cesarean section, then medical direction documentation rules apply (see previous chapter).

EXAMPLES OF OBSTETRIC ANESTHESIA NOTES

For Anesthesia Care for Labor or Labor and Vaginal Delivery

For labor or labor and uncomplicated vaginal delivery, anesthesia care is delivered utilizing epidural (one shot or continuous infusion) analgesia or combined spinal-epidural (CSE) analgesia. The care is delivered in the patient's room and not the operating suite. For these services, personal supervision is usually indicated. Factors that may require direct supervision by the faculty anesthesiologists include inexperience of the resident or complicated medical condition of the patient. For personal supervision, the following are some examples of documentation that meets Medicaid requirements:

Preoperative Note.
"Pt. examined, preop note reviewed. O/W healthy. ASA 1E for LEA"
"Patient examined, preop noted. Preeclampsia, plts normal, ASA IIE for CSE"

Intraoperative Note. (Labor analgesia note)
"LEA in place, VSS, patient comfortable"

"CSE done. VSS. Patient confortable"

Postoperative Note.
"Patient with no complaints. No apparent problems from anesthesia."
"No headache, no leg weakness. No back pain. No apparent complication from anesthesia."

For Anesthesia Care for Cesarean Section

During the cesarean section, direct supervision is indicated at critical portions of the surgery, including uterine incision, delivery of the baby, and the immediate period after. For non-critical portions of the surgery, personal supervision is sufficient. Further, the anesthesia care may be only for the cesarean section or it may have been started during labor with epidural analgesia. In the latter, the labor preoperative note is sufficient, but a new intraoperative note is required for the cesarean section as well as the labor intraoperative note.

Preoperative Note.
"Patient examined, Preop noted. ASA IIE. Spinal"
"Patient examined. Preop note reviewed. Elective repeat c-section. ASA II, SAB"

Intraoperative Note.
"Present and available throughout."
"Present for uterine incision to delivery. Available"

Postoperative Note. (same as above)

Postoperative Notes

Relying on the group practice of anesthesiology, the faculty on duty during the day is responsible to visit and document that indicated postoperative care has been provided. The billing office works with the obstetric anesthesiologists to develop and maintain a process to verify the completion of the documentation.

VERIFICATION AND CHARGE SUBMISSION

Similar to OR anesthesia verification, in facilities that has enough volume to justify billing personnel onsite, prior to submitting the charge to the carrier, documentation is reviewed for completion and meeting all rules by a member of the billing office. Documentation is reviewed on the copy of the record submitted and the postoperative note rounds form. If documentation is incomplete, the medical record is requested and reviewed. If record still is incomplete, then no charge is submitted to the carrier for the services.

In facilities that do not have enough volume, the faculty anesthesiologist will have to complete a billing verification sheet to be submitted with the billing copy of the record. On this sheet, the faculty will note which documentation is complete for the procedure. The billing office will use this as a testament that documentation is complete.

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, including physician assistants and fellows, 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 (Coding, Billing and Documentation Guidelines under The Medicare Teaching Physicians Rules, 1997).

MEDICAL NECESSITY

In cases of emergency or unstable patients, the medical necessity of the critical services is implicit. In other cases, the medical necessity must be documented by the critical care provider

VERIFICATION AND CHARGE SUBMISSION

After Coder reviews documentation, charge is submitted for the services performed. If documentation is incomplete, the faculty anesthesiologist is notified. If documentation is still not complete, then no charge is submitted to the carrier, however, resident service is recorded for reporting purposes.

CARE PROVIDED BY THE PAIN MANAGEMENT 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 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, including physician assistants and fellows 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 (Coding, Billing and Documentation Guidelines under The Medicare Teaching Physicians Rules, 1997).

MEDICAL DIRECTION OF ANESTHESIA CARE AND PAIN MANAGEMENT CARE

As noted in section 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 the section. Pain management care and procedures are not listed in the exceptions. Therefore, if a pain management specialist is providing medical direction for anesthesia care, that **pain management specialist can only provide pain management care if he/she transfer care to another anesthesiologist**. Accurate documentation of these activities requires timing of all notes, including transfer of care notes.

VERIFICATION AND CHARGE SUBMISSION OF CLINIC DOCUMENTS

All charge documents for clinic patients are obtained according to the "Standardized Charge Capture Process" published by the UT-MED, The Group Practice of Medicine, Financial Services. Prior to submitting the charge to the carrier, documentation is reviewed for completion and meeting all rules by a departmental coder. If documentation is not available, then the physician is notified that a dictation or written note is needed. If documentation is still not complete, then no charge is submitted to the carrier.

VERIFICATION AND CHARGE SUBMISSION FOR SURGERY OR PROCEDURES

Charges submitted for procedures performed in the operating room are coded from the operative report in the medical record. Each attending pain management specialist is required to dictate the operative report that indicates his or her involvement in the most demanding part of the procedure at the end of each operative session or no later than the end of the day that the procedure was performed. If the coder does not receive an operative report with one week, the faculty pain management specialist is notified and asked to dictate one immediately.

VERIFICATION AND CHARGE SUBMISSION FOR INPATIENT CONSULTS

Patient names are submitted to the coder on a daily basis for all inpatient consults and follow-ups seen by the pain management service for the previous day. The coder will verify the documentation in the medical record on daily rounds to the floors. If the documentation is deficient the faculty member is notified. If the faculty member does not complete the documentation, a bill is not produced for that service for that day.

DISTRIBUTION OF PLAN AND EDUCATION

CURRENT FACULTY, INCLUDING CRNAS

At the time of adoption (June 1998) of the Departmental Billing Program, all current faculty members, including CRNAs, received a copy of the departmental Billing Compliance Program. Because this material has been previously presented to the faculty, one-on-one meetings similar to those required for new faculty members will not be necessary. All new members since that date have been oriented as listed below. After the new revised compliance plan is final, it will be distributed to all faculty, including CRNA.

NEW FACULTY, INCLUDING CRNAS

At the time of appointment of a new CRNA or faculty member, he/she will have a one-on-one meeting with the compliance officer to cover the compliance plan. At that time, the billing compliance plan is distributed. Within the first month of appointment all new faculty physicians will have a one-on-one meeting with the anesthesiology billing manager to review documentation and answer any questions in regards to billing, documentation, and compliance as it relates to coding and submission of claims to third party carriers.

RESIDENTS, FELLOWS

The Billing Compliance Plan was distributed to the current residents and fellows in July 1998 and to new residents and fellows every July thereafter. In July of each year, there shall be a presentation to the new residents about documentation and the anesthesia record. An initial lecture on the compliance plan was given to all residents and faculty for July 24, 1998. Thereafter, periodic presentations will occur as needed.

OVERSIGHT AND REVIEW

INCOMPLETE DOCUMENTATION REPORT

A record of incomplete documentation for services performed is kept in the billing office. The head of the billing office and the compliance officer reviews a monthly summary. Quarterly reports are presented at the Quality Committee for the department.

SPECIAL CLINICAL AREAS

The head of the Billing Office will meet at least quarterly with people in charge of each of the areas, i.e., the Pain Clinic, and the SICU. For the main OR, the head of the billing office will meet with the Departmental Billing Compliance Officer.

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 documentation. Post-billing (after charges submitted) reviews are not done except under the direction of legal counsel.

NONCOMPLIANCE

Clinical members of the department: (e.g., Faculty, CRNA, resident)

If a specific person is identified as failing to comply with this plan, resulting in consistent non-billing or inappropriate billing, then he/she will first be counseled by the Departmental Billing Compliance Officer, and, if necessary, by the Chairman.

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, or the Administrator. 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 and UH#, 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 Compliance, UTMB via the Hotline at 1-800-898-7679.

REFERENCES

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