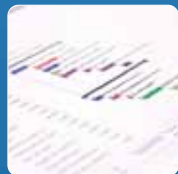


WATCHING THE CLOCK: ANESTHESIA START-STOP TIME ACCURACY KEY TO AVOIDING COMPLIANCE PROBLEMS

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Among the major medical specialties, anesthesiology has long represented a relatively small percentage of total healthcare costs and thus generally has not been the target of aggressive payor scrutiny or audits.

But that will likely change as the government's new Medicare audit initiatives gain traction. Chief among these programs is the Recovery Audit Contractors Program (RACs), a nationwide effort that relies on independent contractors to ferret out improper provider payments in exchange for a percentage of the dollars recovered.

Because of the incentivized nature of the RACs program, reimbursement investigations are expected to be pursued in numbers and with a tenacity not previously witnessed in the Medicare arena. As a result, anesthesiologists should take steps today to ensure that billing policies comply with both public and commercial reimbursement guidelines.

One area that bears particular attention is the recording and subsequent billing of anesthesia start and stop times. Too often, anesthesiologists and CRNAs lack a clear understanding of when anesthesia time starts and ends. The result can be overbilling, which leaves the group vulnerable to compliance action, or underbilling, which can cost the practice money.

In any case, ensuring that practitioners understand what constitutes anesthesia time is important both for reducing compliance risk and strengthening collections.

DEFINING TIME

CMS defines surgical anesthesia time as the continuous, actual presence of the anesthesiologist or CRNA. Surgical anesthesia time begins when the physician or CRNA starts preparing the patient for the anesthesia procedure -- in the operating room or equivalent area -- and ends when the anesthesia practitioner is no longer in personal attendance.

The CPT definition is similar: "Anesthesia time begins when the anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room or in an equivalent area and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient may be safely placed under postoperative supervision."

In both definitions, time is counted from the moment the practitioner -- having completed the preoperative evaluation -- starts an intravenous line, places monitors, administers pre-anesthesia sedation or otherwise physically begins to prepare the patient for anesthesia. Time continues through the case and the period during which the practitioner accompanies the patient to the post-anesthesia recovery unit (PACU). Time stops when the practitioner releases the patient to the care of the PACU personnel. It is important to note that the time spent reviewing the patient's medical record prior to surgery is not billable anesthesia time. This is considered part of the pre-operative evaluation which is compensated through the procedure's base units.

Acute post-op pain services and invasive monitoring lines used in conjunction with anesthesia also factor into the reporting of total anesthesia time. The treatment of the time required to perform these services is contingent upon when they are performed during the patient's surgical care.

Specifically, when provided before anesthesia time starts (pre-operatively) or after it has ended (post-operatively), the time spent performing these services should not be included in anesthesia time. This is true for pain blocks, irrespective of the level of sedation and monitoring that is provided to the patient for the block. Conversely, when the block is provided intra-operatively, the time spent placing the line or performing the post-op pain service is not subtracted from total anesthesia time.

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DISCONTINUOUS TIME

CMS and most insurers recognize that there may be breaks or interruptions in anesthesia care wherein the anesthesia practitioner is no longer in personal attendance with the patient. When this occurs, the practitioner is allowed to include the blocks of time before and after the interruption, as long as the practitioner is furnishing continuous anesthesia care within the time periods being reported.

Here are several examples of the appropriate use of discontinuous time:

- › The anesthesiologist has begun preparing the patient for induction, but the surgeon is temporarily unavailable and the anesthesiologist leaves the patient under the observation of non-anesthesia personnel.
- › An IV is started in the induction room, but there may be a break before induction of anesthesia in the operating room. As long as there is continuous monitoring of the patient within the blocks of anesthesia time, those blocks may be aggregated.

Accounting for discontinuous time should be done with precision. For example:

- › 7:55 a.m.: CRNA starts an IV and places monitors in pre-op
- › 8:02 a.m.: CRNA leaves patient in pre-op with OR personnel (start of discontinuous time)
- › 8:26 a.m.: CRNA returns and takes patient to operating room; case ends at 9:56 a.m.
- › 10:02 a.m.: Patient is released to PACU personnel

In this case, anesthesia time equals 103 minutes (127 total minutes minus 24 minutes of discontinuous time). Fortunately, most practice management and documentation software applications allow for the entry of multiple anesthesia start and stop times to accommodate discontinuous time.

RELIEF TIME

Relief time or split time occurs when one physician takes over a case for another physician in the group. In these instances, two separate start/stop time lines should be documented on the anesthesia record and charge ticket. The case should either be billed under the name of the physician who spent the most time with the patient or under the name of the physician who started the case.

IMPROPER ROUNDING

One area involving anesthesia time that frequently can lead to problems is imprecision in recording the minutes involved. Because Medicare recognizes 15-minute time units and pays to the tenth of a unit (1.5 minutes), physicians should report exact minutes for both start and stop times. Too often, groups round to the nearest 5-minute increment, or worse, estimate the time involved based on past experience. A good indication of potentially inappropriate rounding is if more than 20 percent of a practice's start and stop times are fixed on five-minute intervals.

PROVIDING ADDITIONAL INFORMATION

To ensure compliant claims and appropriate reimbursement, additional documentation should be included in certain circumstances or situations. As a general rule, if more than 15 minutes pass from the anesthesia start time to the time the patient is taken into the operating room, the delay should be explained in the anesthesiologist's notes.

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Similarly, if more than 15 minutes elapse between the OR time and the start of surgery, an explanation should be provided. Finally, the industry standard for the amount of time between transferring the patient to the recovery room and the anesthesia stop time is 5-to-15 minutes. If it is longer than this, the documentation should clearly explain the reasons for the prolonged anesthesia time.

PRECISION IS KEY

As government and commercial payors become more aggressive in their pursuit of improper provider reimbursements, more anesthesiology groups can expect to face audits and investigations of clinical documentation, coding and claims procedures. Start-stop times represent one area of major vulnerability for anesthesia groups. As a result, it behooves practices to revisit their start-stop time procedures to ensure that rigorous compliance policies are firmly established and in place -- before the auditors arrive.

Cody P. Jones, CPA, MBA, ChFC is a director of practice management with MMP. He began his career in anesthesia practice management by joining Medical Management, Inc. in 1994. Previously, he spent three years as a tax specialist with the public accounting firm of Deloitte and Touche. From April 1997- September 2000, Cody served as the practice administrator for Medical Anesthesia Group, P.A. (MAG) in Memphis, Tennessee. In September 2000, he joined Millennium Medical Management, Inc., a national anesthesia-consulting firm located in Atlanta. Cody joined ICON (acquired by MMP in 2007) in May 2001. Since that time, he has earned the Chartered Financial Consultant (ChFC) designation. He is a member of the Healthcare Financial Management Association, Medical Group Management Association, American College of Medical Practice Executives, Society of Financial Service Professionals, American Institute of Certified Public Accountants, and the Alabama Society of Certified Public Accountants. Cody maintains an active Alabama and Georgia CPA license.

About MMP

Medical Management Professionals, Inc. (MMP) was founded in 1993 and is a provider of billing and practice management services to emergency medicine physicians. MMP's flexible solutions range from billing-only services to full-practice management services. For more information about MMP, visit www.cbizmmp.com.

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