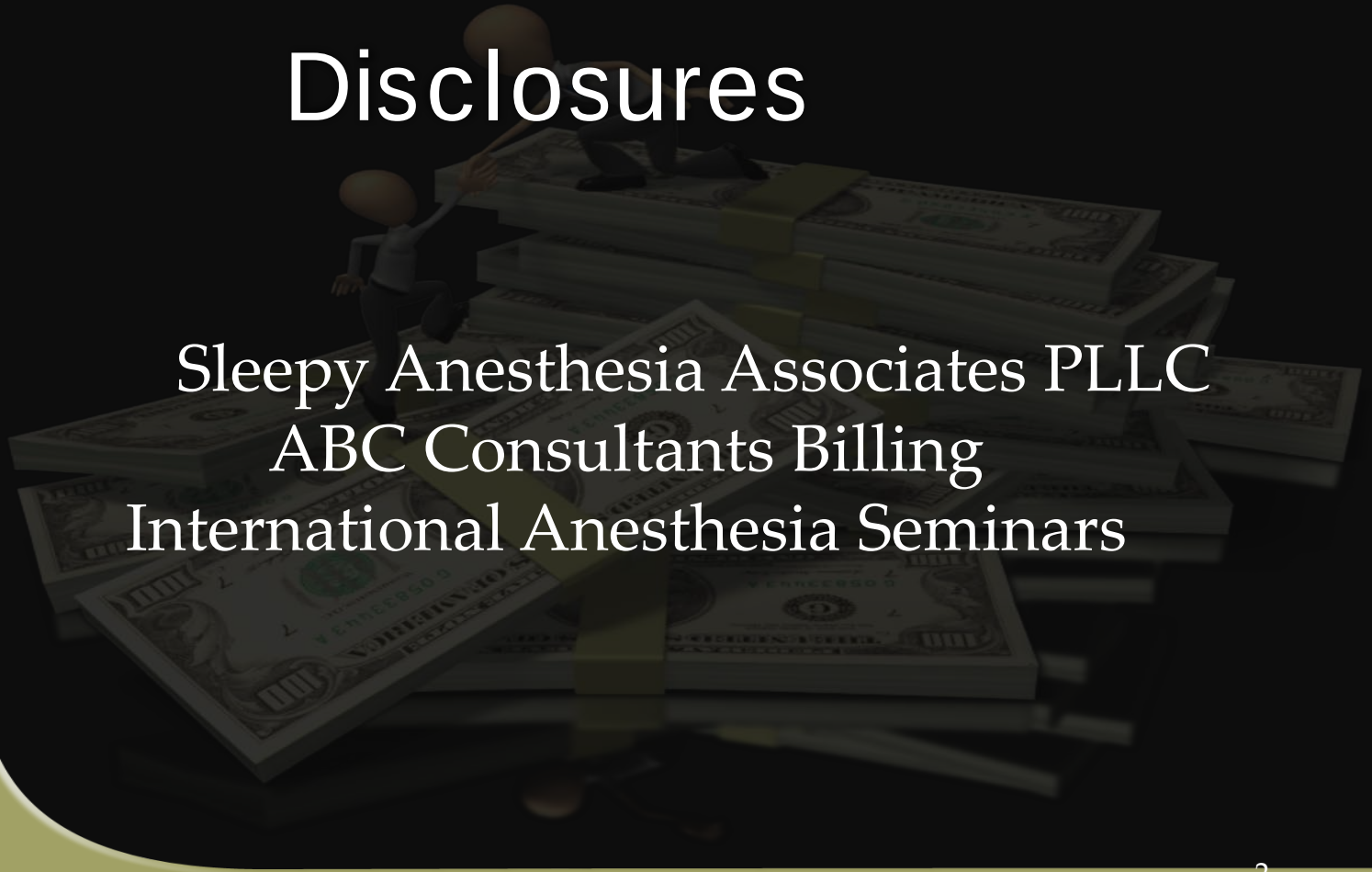
Reimbursement

Juan F. Quintana
CRNA, DNP

Disclosures



Sleepy Anesthesia Associates PLLC
ABC Consultants Billing
International Anesthesia Seminars

Agenda

1. CMS - Medicare
2. Components of a Bill
3. Productivity
4. Billing Costs and Problems
5. Barriers to CRNA Billing
6. Regulatory Concerns /Issues

Medicare

CHIPS

Medicaid

Knowledge is the Key

CMS → U.S. - DHHS

Medicare Numbers

Provider → NPPES → NPI

6 weeks to 3 months

NPI → MAC CMS 855 (PECOS) → PTAN

MACs

Medicare Administrative Contractor

E & F - Noridian (1,2,3) AK, AZ, CA, HI, ID, MT, NV, OR, Pacific Islands, SD UT, WY

H & L - Novitas (4, 7, 12) AR, CO, DE, LA, MD, MS, NJ, NM, OK, PA, TX, Washington DC

G - WPS (5,6) IA, IL, KS, MN, MO, WI

I - CGS (15) KY, Ohio; WPS (8) IN, MI

N - First Coast (9) - FL, PR, US Virgin Islands

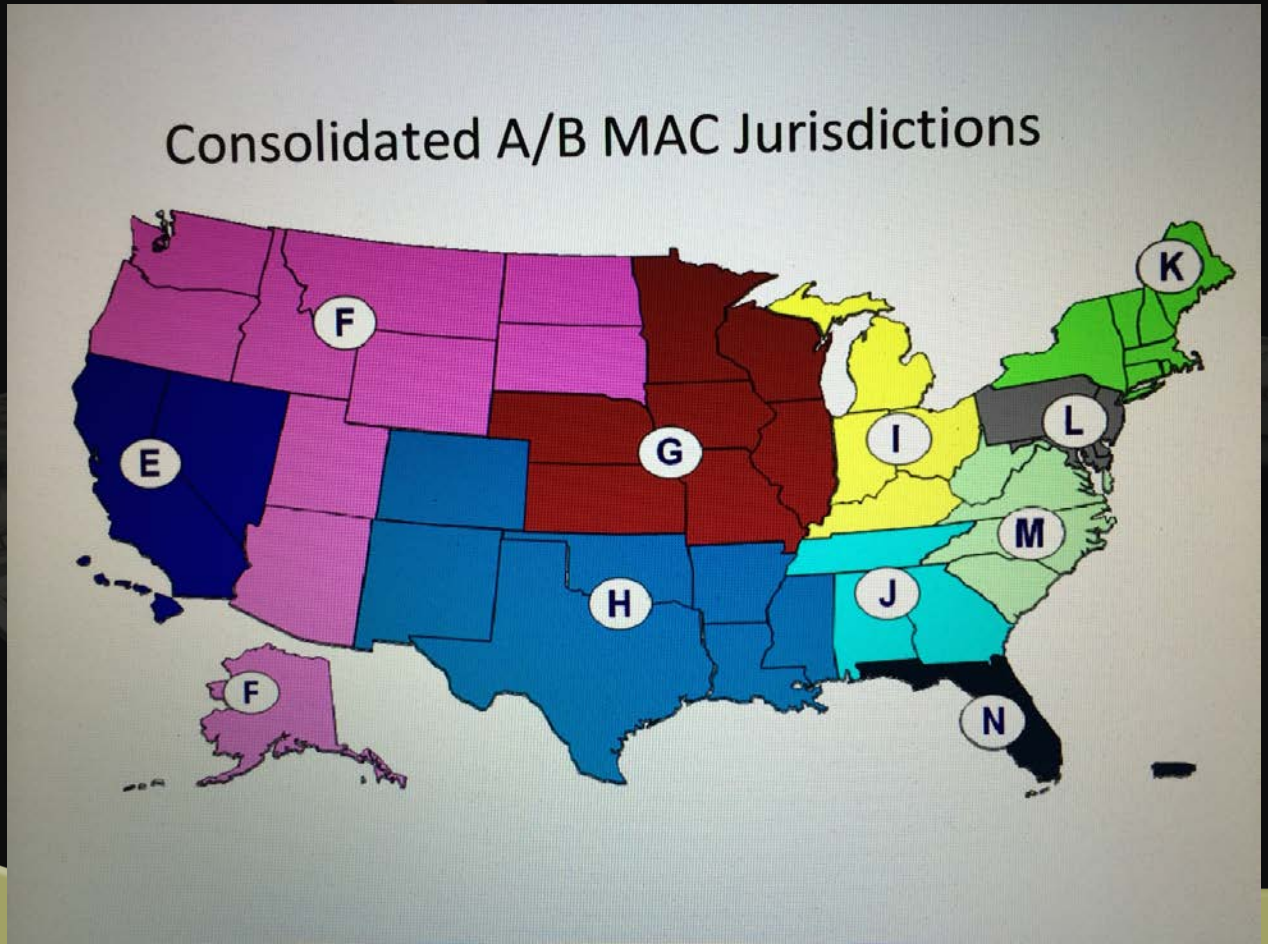
J - Cahaba (10) AL, GA, TN

K - NGS (13, 14) CT, MA, ME, NH, NY, RI, VT

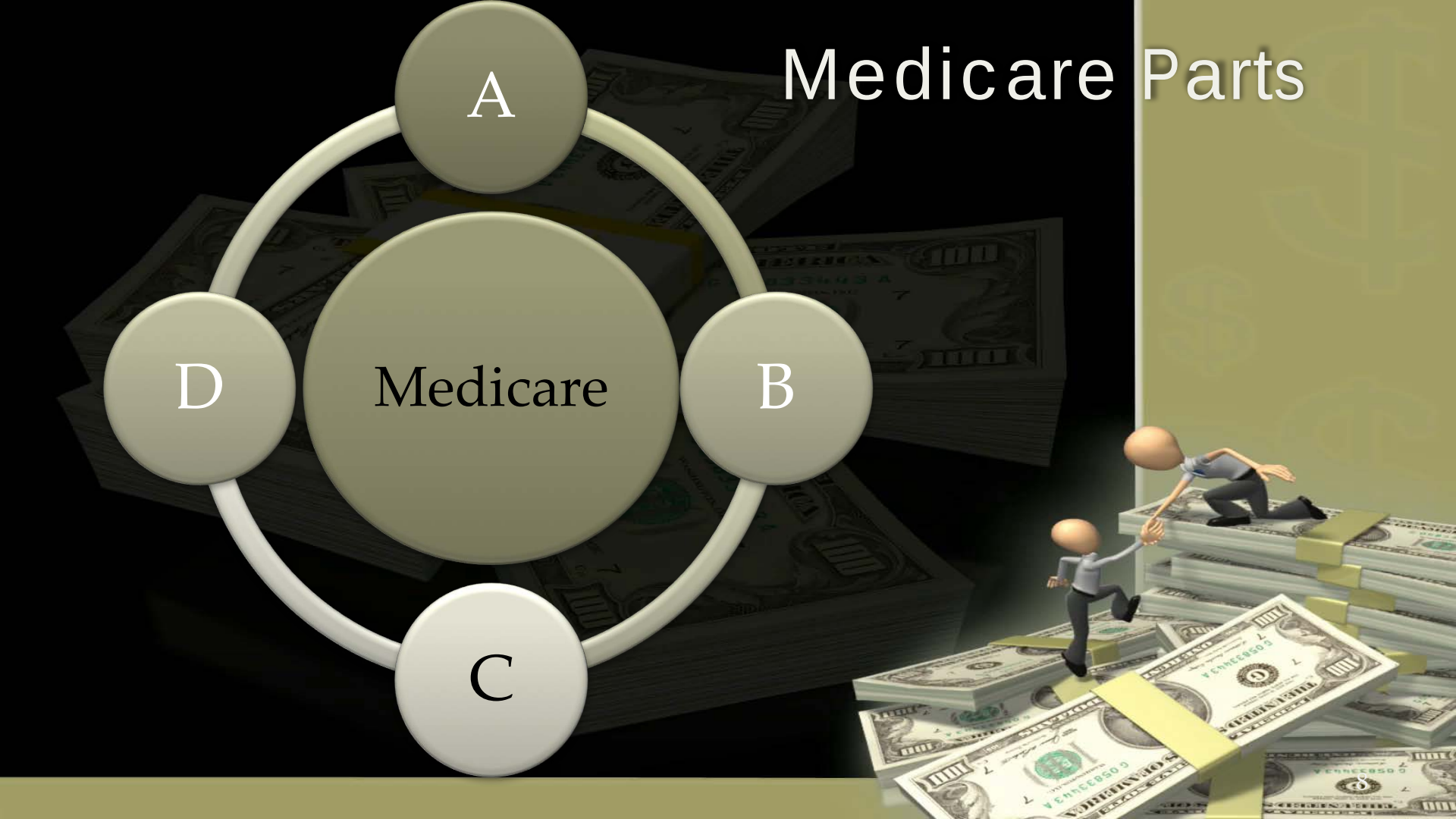
M - Palmetto GBA (11) NC, S C, VA, WV

Medicare Administrative Contractor

MACs



Medicare Parts



Medicare Part A

Inpatient hospital care,
Skilled nursing care,
Hospice care
Other services.

Paid by Social Security Tax

Medicare Part B

Helps pay:

- Doctors' fees
- Outpatient hospital visits
- Medical services/supplies not covered by Part A.

Paid by premiums of people enrolled and general funds from the U.S. Treasury

Medicare Part C

Medicare Advantage

Must be enrolled in A & B

Paid by additional Monthly Fee

Medicare Part D

Prescription Drug Plan

Paid by premiums of people enrolled and Medicare

Opt Out

Medicare Reimbursement

Medicare Part A

Hospital Conditions of Participation

Supervision

Medicare Part B

No Supervision Requirement

Anesthesiologists Center

Medicare Claims Processing Manual
Chapter 12 - Physicians/Nonphysician Practitioners
Table of Contents
(Rev. 2914, 03-25-14)

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

50 - Payment for Anesthesiology Services

(Rev. 1859; Issued: 11-20-09; Effective: 01-01-10; Imp: 01-04-10)

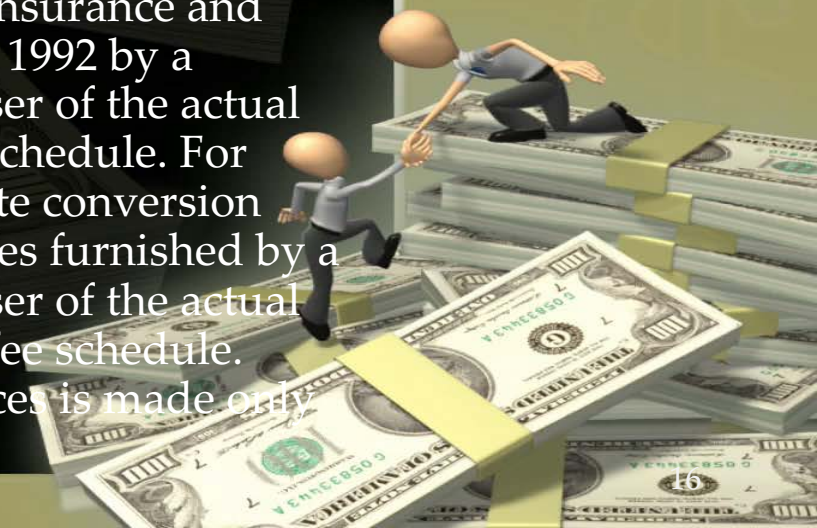
A. General Payment Rule

The fee schedule amount for physician anesthesia services furnished on or after January 1, 1992 is, with the exceptions noted, based on allowable base and time units multiplied by an anesthesia conversion factor specific to that locality.

140 - Qualified Nonphysician Anesthetist Services (Rev. 2716, Issued: 05-30-13, Effective: 01-01-13, Implementation: 02-12-13)

Section 9320 of OBRA 1986 provides for payment under a fee schedule to certified registered nurse anesthetists (CRNAs) and anesthesia assistants (AAs). CRNAs and AAs may bill Medicare directly for their services or have payment made to an employer or an entity under which they have a contract. This could be a hospital, physician or ASC. This provision is effective for services rendered on or after January 1, 1989.

Anesthesia services are subject to the usual Part B coinsurance and deductible and when furnished on or after January 1, 1992 by a qualified nonphysician anesthetist are paid at the lesser of the actual charge, the physician fee schedule, or the CRNA fee schedule. For services furnished after January 1, 1996, when separate conversion factors for CRNAs were eliminated, anesthesia services furnished by a qualified nonphysician anesthetist are paid at the lesser of the actual charge, the physician fee schedule, or the anesthesia fee schedule. Payment for qualified nonphysician anesthetist services is made only on an assignment basis.



Agenda

CMS - Medicare

Components of a Bill

Productivity

Billing Costs and Problems

Barriers to CRNA Billing

ICD-10

International Statistical Classification of Disease and Health Related Problems

There are 14,000 diagnosis codes in ICD-9; ICD-10 contains about 104,000.

815690

4280

4019

Rectal Polyps

CHF

HTN

Colonoscopy

Current Procedural Terminology

Anesthesia
0100 - 01999

Source: Relative Value Guide

Anesthesia Services

Type of Service TOS

Surgical	Anesthesia
2	7

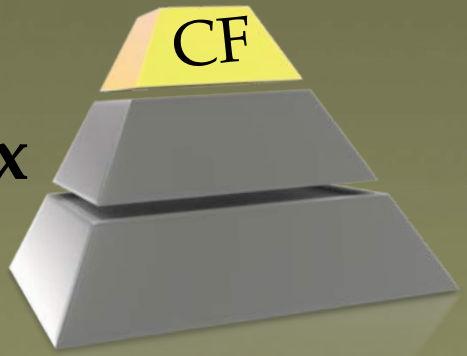
http://www.cms.gov/manuals/downloads/clm104c26.pdf
(section 10.7)

TOS 7

Components of Anesthesia Bills

+

x



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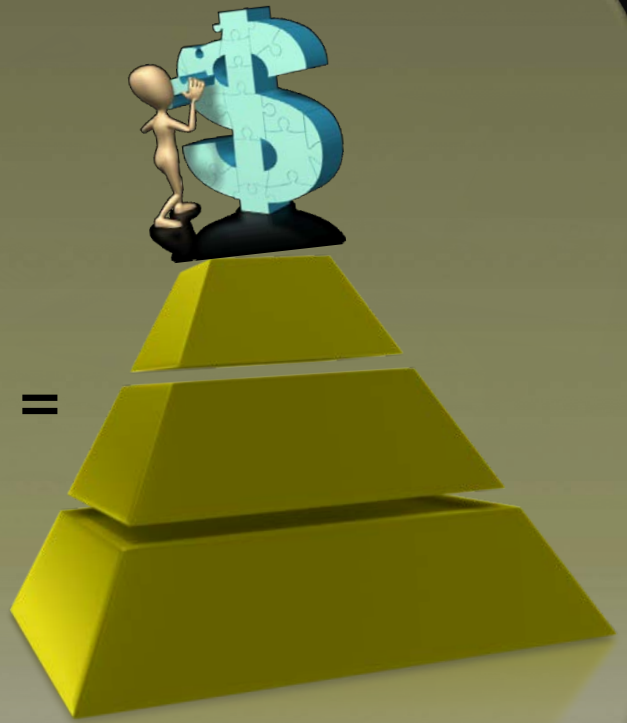


Patient examination and evaluation prior to surgery

Postoperative evaluation

Base Units

1 unit = 15min.

TM

Financial Remuneration

$$$ / unit

CF

Components of Anesthesia Bills

Anesthetic Management TOS 7

Base Units

Includes:
- Pre/Post Op visits
- Administration of fluids/blood
- Interpretation/ Monitoring - ECG, Temp, BP, SaO2, CO2, mass spectrometry

Excludes:
- Time
- Modifiers
- Arterial/central line
- TEE

Reference: Relative Value Guide 2013 pg X.

140.3.2 - Anesthesia Time and Calculation of Anesthesia Time Units

(Rev. 2716, Issued: 05-30-13, Effective:01-01-13, Implementation: 02-12-13)

Time Units

Defined - the period during which an anesthesia practitioner is present with the patient.

Starts when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the patient, that is, when the patient may be placed safely under postoperative care.

Conversion Factors

Medicare Conversion Factors

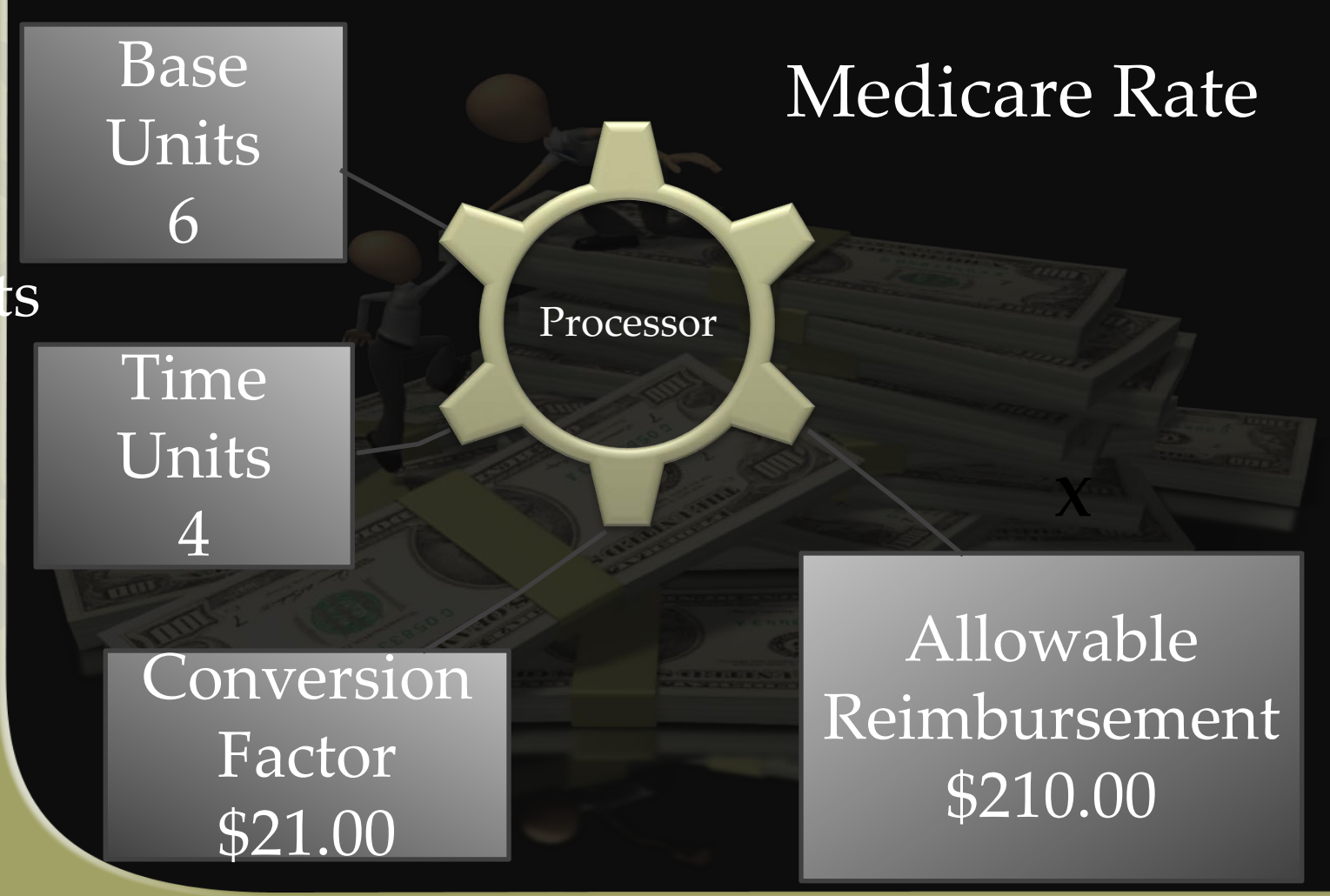
http://www.cms.gov/center/anesth.asp

-Billing /Payment

Commercial Conversion Factors

http://www.asahq.org/for-members/practice-management/asa-survey-results-for-commercial-fees-paid-for-anesthesia-services.aspx

Components Of Anesthesia Bills



Correct CPT Codes

01202 Anesthesia for arthroscopic procedures of the hip joint 4 + TM

01210 Anesthesia for open procedures involving hip joint 6 + TM

01214 Total Hip Arthroplasty 8 + TM

01210 = 6 + TM

6 + 8 = 14

14 x $50 = $700

01214 = 8 + TM

8 + 8 = 16

16 x $50 = $800

Sample 1 Hip Replacement

Correct CPT Codes

00700 Anesthesia for procedures on upper anterior abdominal wall 4 + TM

00790 Anesthesia for intraperitoneal procedures in upper abdomen including laparoscopy: not otherwise specified 7 + TM

00840 Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy: not otherwise specified 6+ TM

Sample 2 Cholecystectomy

00700 = 4 + TM	00790 = 7 + TM
4 + 6 = 10	7 + 6 = 13
10 x $50 = $500	13 x $50 = $650

Anesthesiologists Modifiers

AA - Anesthesia performed by the MDA

AD - Medical Supervision; > 4 concurrent procedures

QY - Medical direction 1 CRNA

QK - Medical direction 2,3 or 4 concurrent procedures

GC – services performed by a resident under the direction of a teaching physician.

CRNA Modifiers

QX - CRNA medically directed

QZ – CRNA not medically directed

No modifiers for Teaching SRNA

140.3.3 - Billing Modifiers
(Rev. 2716, Issued: 05-30-13, Effective:01-01-13, Imp: 02-12-13)

MODIFIERS

Physical Status (ASA)

P1, P2, P6	0
P3 Severe Systemic Disease	1
P4 Constant threat to life	2
P5 Moribund may /may not live	3

Others

22 Increased Procedure Services – not E/M

23 Unusual Anesthesia

25 E/M – significant need

26 Professional Component

50/51 Bilateral/Multiple Procedures **(not TOS 7)**

59 Distinct Procedure Service - Blocks

Add-On codes

Extra CPT codes (act like modifiers)

Age <1 or >70	1
Hypothermia	5
Hypotension	5
Emergencies	2

Bilateral (50)/Multiple Procedures (51)

More than one procedure on a patient during an anesthetic?

- Report Anesthesia code with highest Base Units
- Report total time for all procedures

Reference Relative Value Guide 2013 pg. XI

Distinct Procedural Service -59

Why? Most widely used modifier – abuse/Fraud

January 2015

4 new Modifiers – subsets of -59

(don't report -59 w/ these)

-X (EPSU) modifiers

XE – separate encounter

XP – separate organ/structure

XS – different provider

XU – unusual non-overlap of service

Monitored Anesthesia Care Modifiers

QS - Monitored anesthesia care service

G8 - Monitored anesthesia care (MAC) deep complex complicated, or markedly invasive surgical procedures

G9 - Monitored anesthesia care (MAC) patient w/ history of severe cardio- pulmonary condition

Noridian MAC criteria

To MAC or not to MAC?

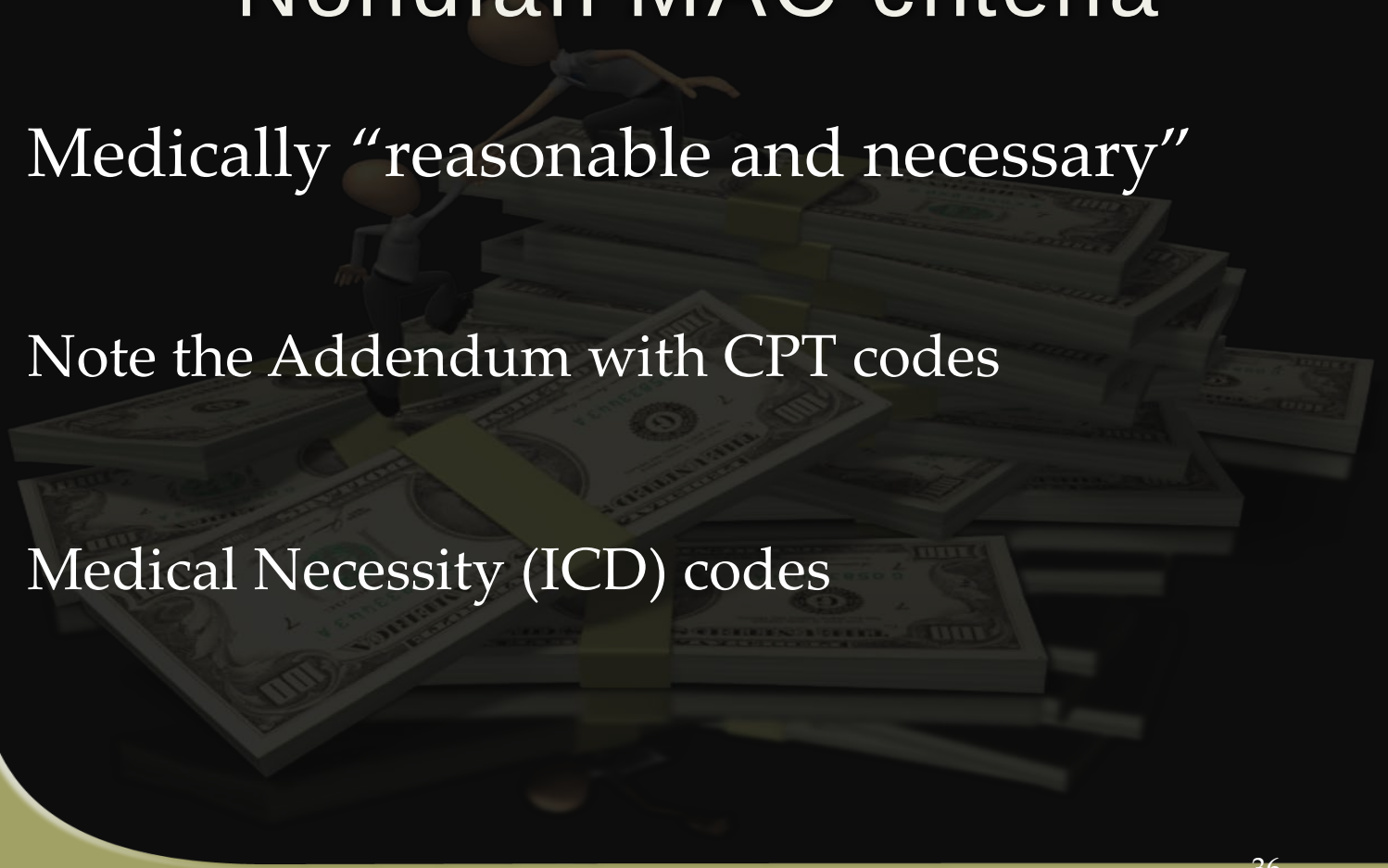
LCD ID Number
L24332

LCD Title
Monitored Anesthesia Care (MAC)

Contractor's Determination Number
B2006.14 R11

To MAC or not to MAC?

Noridian MAC criteria



Medically “reasonable and necessary”

Note the Addendum with CPT codes

Medical Necessity (ICD) codes

Type of Service 2

Conversion Factor – annually decided by CMS

2014 ~ $35.82

Procedure related, not time related

140.4.3 Payment for Medical or Surgical Services Furnished by CRNAs

(Rev. 2716, Issued: 05-30-13, Effective:01-01-13, Implementation: 02-12-13)

Payment shall be made for reasonable and necessary medical or surgical services furnished by CRNAs if they are legally authorized to perform these services in the state in which services are furnished.

Interventional Pain Management

AANA Position

Pain management is within CRNA professional scope.

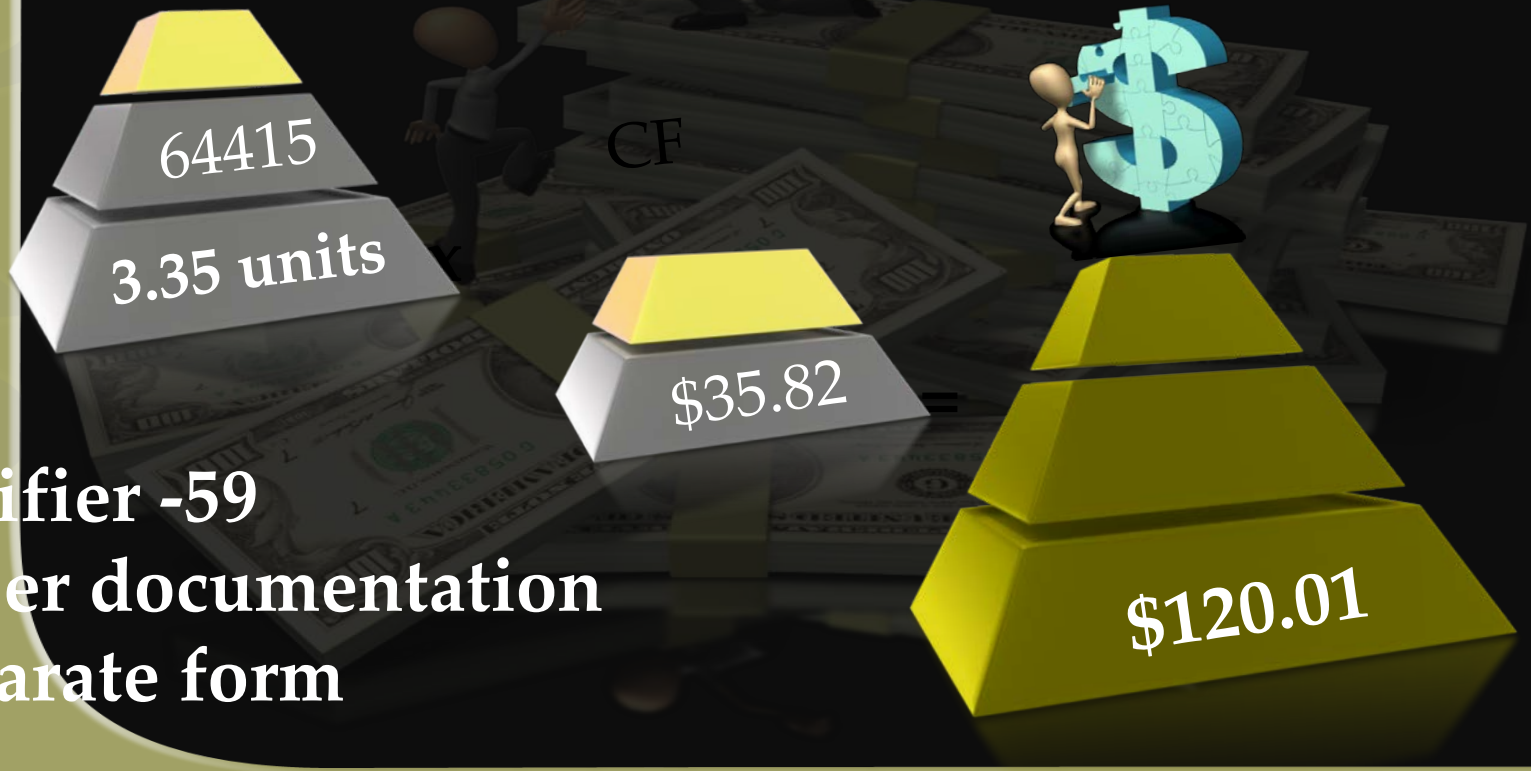
State law governs what CRNAs may do in particular state.

Medicare rule, confirms that the federal government recognizes CRNAs as qualified pain management providers.

TOS 2

Components of Anesthesia Bills

Brachial Plexus Block



Add modifier -59
Add proper documentation
Separate form

Exceptions – Local Coverage Determinations

National Coverage Determinations vs. LCDs

e.g. NHIC corp. Jurisdiction 14

1 unit billed per block

MACRA: Medicare Access and CHIPS Re-Authorization ACT

Quality Payment Program

Alternative Payment Models - APMs

- Innovative Model

Merit based Incentive Payment System

MIPS – Performance Model

Merit-Based Incentive Payment System

MIPS

Eliminates:

PRQS, VBM and EHR

New:

Quality,

Resource Use (FYI – Cost Appropriation)

Clinical Practice Improvement Activities

EHR (FYI – Data submission)

scores

Merit-Based Incentive Payment System

MIPS

Quality – measures published annually by CMS
- QCDR measures

Resource – Cost measures
- Attribution

EHR – Criteria to be deemed meaningful use

Merit-Based Incentive Payment System

MIPS

Clinical Practice Improvement Activities (CPIA)

- Expanded Access
- Population Management
- Care Coordination
  - communication, tele-health
- Beneficiary engagement
- Patient Safety/Practice Assessment
- Participation in some APMs

Performance:
MIPs - record quality data/ technology
APM – join/ provide care through that model.

Submit performance data:
MIPs - payment adjustment on data from 2017 by March 31, 2018.
APM - 5% incentive for significantly participation.

Feedback: Medicare gives you feedback
Payment:
MIPS payment adjustment in 2019
APM - 5% incentive payment in 2019.

MIPS Adjusted Payments?

Composite performance score

positive, negative or neutral adjustment

Adjustments are to Medicare Part B payments

MIPs 2017 measures

#76 Central Venous Catheter

Met – 6030F, Not Met – 6030 8P

Exception – 6030 1P

#404 smoking abstinence

Met – G9644, not Met – G9645

#424 Temperature Mgmt – case over 1hr (4255F)

Met – G9771, not Met – G9773

Exception – G9772

#426/#427 PACU/ICU transfer

Met - G9655/0583F, Not Met G9658/0583F 8P

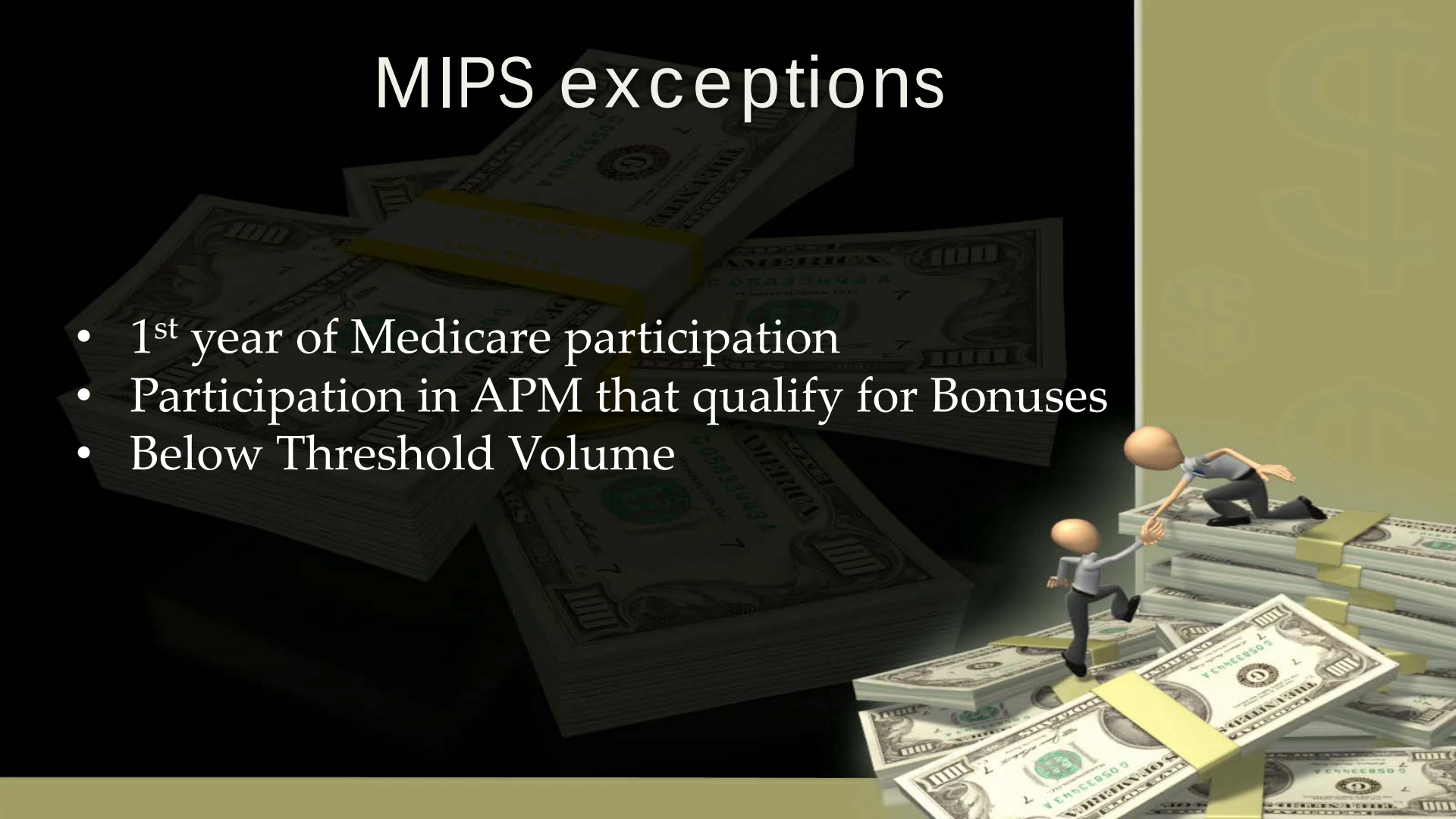
#430 PONV – at least 2 anti-emetics

Met – G9775, Not Met – G9777

Exception – G9776

MIPS exceptions

- 1st year of Medicare participation
- Participation in APM that qualify for Bonuses
- Below Threshold Volume



Alternative Payment Models

APMs include:

- CMS innovation Center model
- Medicare Shared Savings Program (ACOs)
- Demonstration – Quality Demo program
- Demonstration – required by Law

Alternative Payment Models

APMs

EPs who derive a significant portion of their payments/patients from APMS

Risks Financial Losses
Use Quality measures
EHRs

Alternative Payment Models

APMs – What's "significant"

2019-2020

25% CMS FFS pay from APM

2021-2022

50% CMS FFS pay from APM or

50% all payments and 25% CMS from APM

2023 …

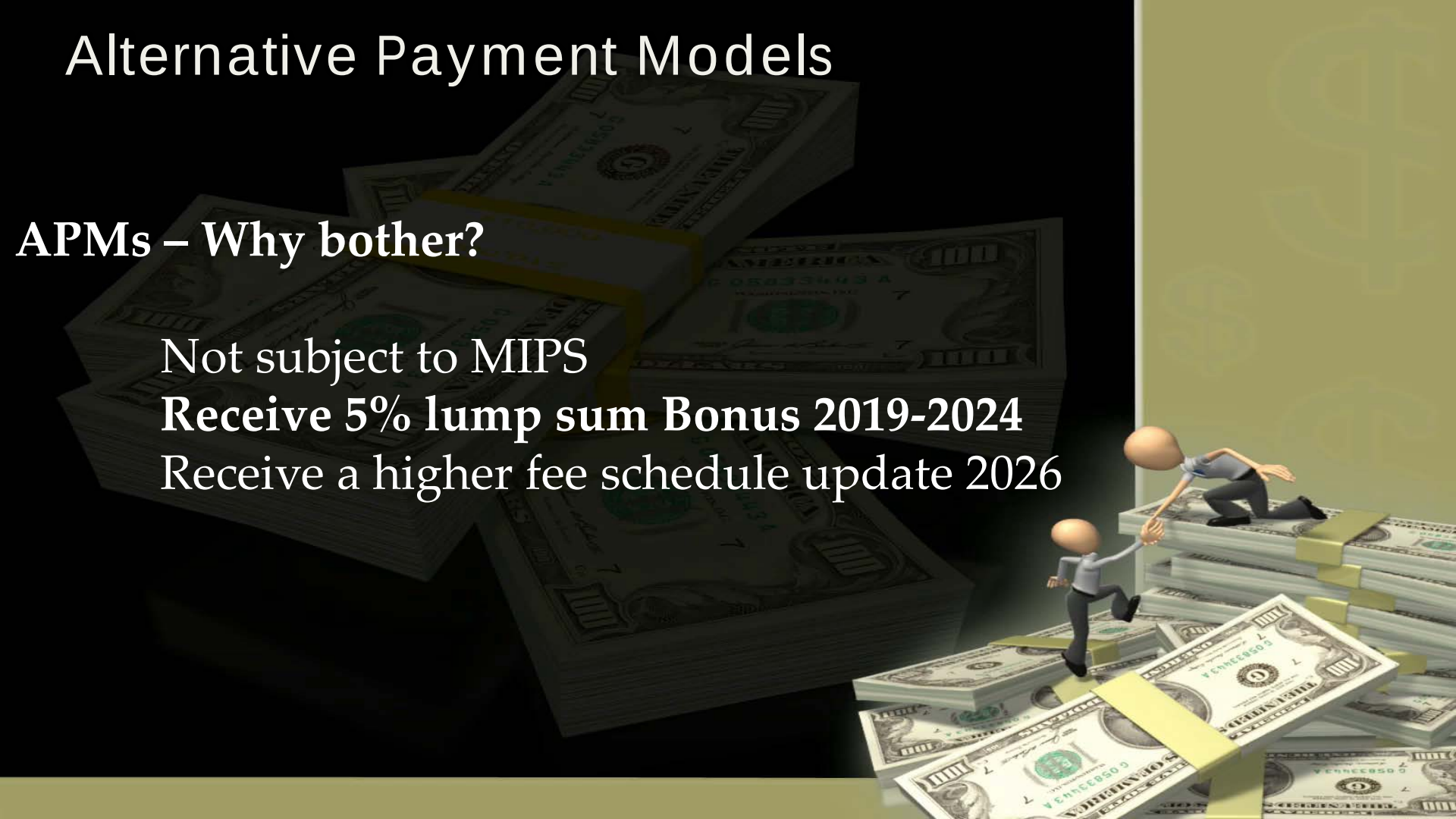
75% CMS pay from APM or

75% all payments and 25% CMS from APM

Alternative Payment Models

APMs – Why bother?

Not subject to MIPS
Receive 5% lump sum Bonus 2019-2024
Receive a higher fee schedule update 2026



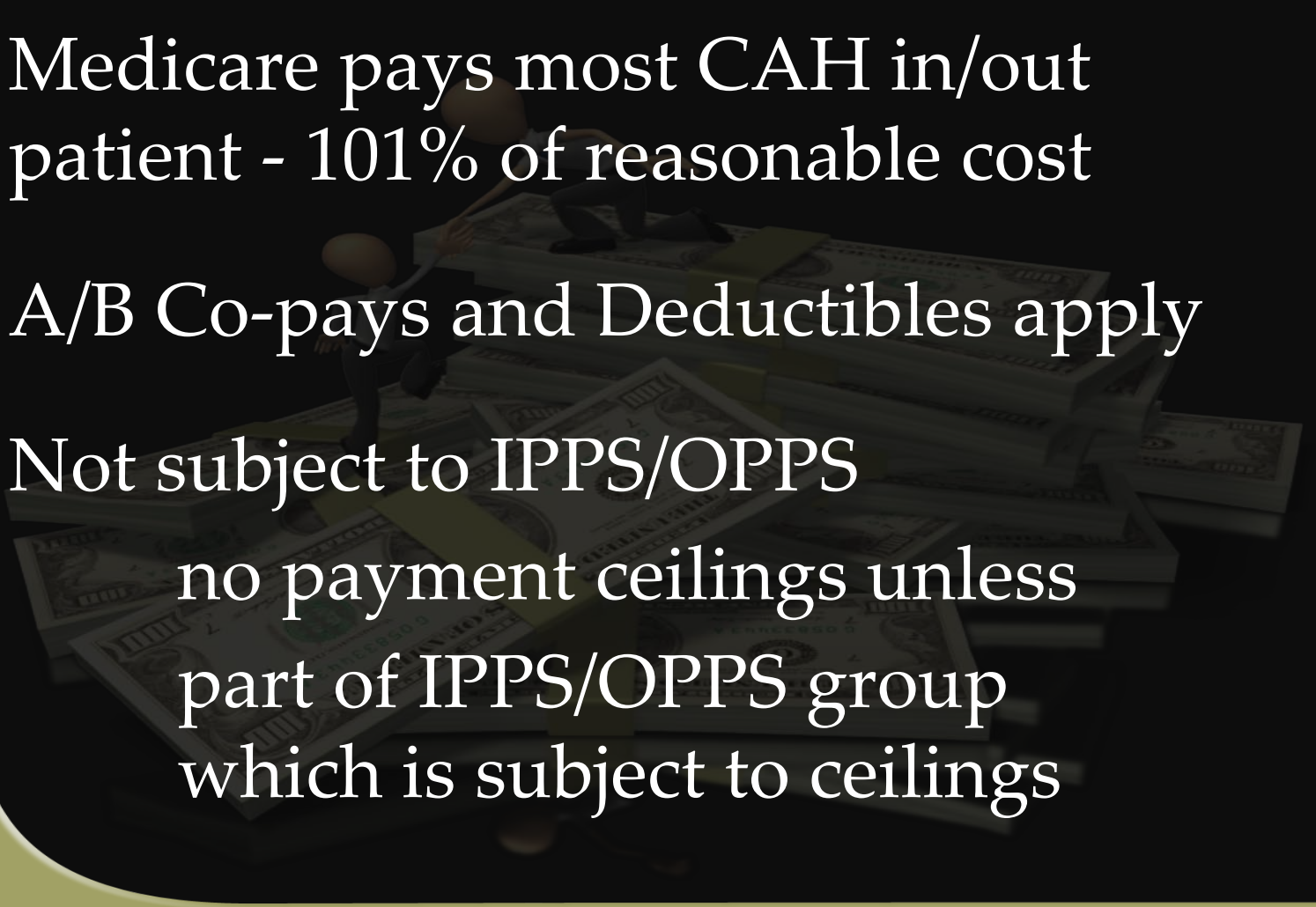
CAH

Medicare pays most CAH in/out patient - 101% of reasonable cost

A/B Co-pays and Deductibles apply

Not subject to IPPS/OPPS

- no payment ceilings unless part of IPPS/OPPS group which is subject to ceilings



CAH Payment Methods

Standard Payment Methodology

-Section 1834(g)(1) Social Security Act-

Outpatient services (101% reasonable cost)

Physician fees - Outpatient (paid by MAC)

Physician Fee Schedule (PFS) – Part B

Optional Payment Methodology

Section 1834(g)(2) Social Security Act-

Outpatient (101% reasonable cost)

Professional services (115%) billed to MAC

Professional reassigns billing to CAH (855-R)

CAH Provider Re-assigned Billing

Optional Payment Method

1. Agrees to be billed under reasonable cost basis = gets paid by facility
2. Attestation NOT to bill for services
3. Cannot bill Part B

Doesn't encompass all the providers

*Professional retains billing rights bills PFS

Rural Pass-Through

Requirements - 42 CFR 412.113(c)

CAH/Rural Pass-Through

CRNA/AA employed or Contracted

Less than 800 surgical procedures prior year

CRNA(s) works less than 2080 hours

CRNA agrees not to bill Medicare for patient services in that facility

Sept 30 – Jan 1

Rural Pass-Through

Available for either Standard/Optional Payment Method

Unless included in Outpatient Pro services Optional Payment Method

CMS estimates CRNA pass-through about $240k

800 cases x 9units /case = 7200 units

7200 units x $21.00 = $151,200

Negotiate your rate!!

CRNA
Relations

Anesthesia Agreements

Sky's the limit!!

- CRNA employed
  - CAH Bills
  - CAH outsources billing
- CRNA contracted
  - CAH Bills
  - CAH outsources billing
  - Stop Gap relationships
  - Flat fees/Stipends

Agenda

CMS - Medicare

Components/Calculation of a Bill

Productivity

Billing Costs and Problems

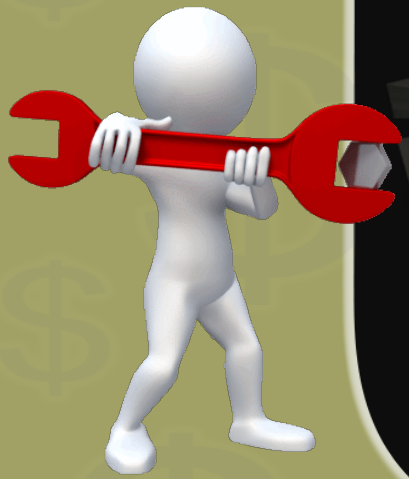
Barriers to CRNA Billing

Productivity

Defined – total output /one unit of input

A Measure of efficiency

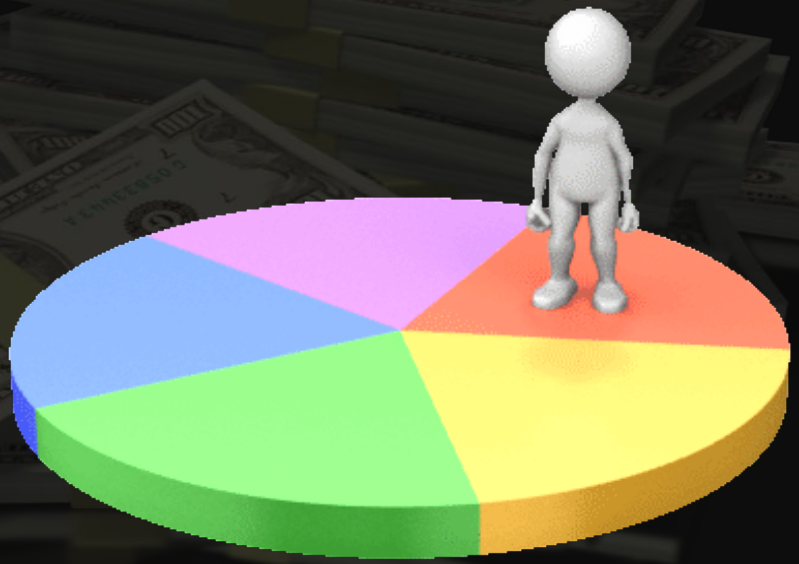
Ratio of Output to Input



Payer Mix

The percentage of reimbursement from the individual payers

- Medicare
- Medicaid
- Commercial
- Private payer



Sum = 100%.

Payer Mix

Sample

Percentage Payer	x CF	
40% Medicare	x $21.00 =	$08.40
40% Commercial	x $50.00 =	$20.00
10% Medicaid	x $15.00 =	$01.50
10% Private Pay	x $00.00 =	$00.00
Average $$$ / Unit		**$29.90**

Estimating Annual Productivity

ASSUME

TOS provided - 7

Payer Mix - Medicare

Average Days worked = 255

Average Procedures/ day = 4 or 5

Average CF r/t TOS = $21.00

Average Units/Procedure = 10-13

Medicare Only
Sample Productivity

Procedure Revenue

10 units/procedure x $21.00/units =
$210.00/procedure

Daily Revenue

$210.00/procedure x 5 procedures/day
$1050.00/day

Yearly Revenue

$1050.00/day x 255 days/year
$267,750.00/year

Combined Payer Mix Sample Productivity

Procedure Revenue

10 units/procedure x $29.90/units =
$299.00/procedure

Daily Revenue

$299.00/procedure x 5 procedures/day
$1495.00/day

Yearly Revenue

$1495.00/day x 255 days/year
$381,225.00/year

Agenda

CMS - Medicare

Components of a Bill

Productivity

Billing Costs and Problems

Barriers to CRNA Billing

Billing Costs

Average Billing Costs

- 4-10% of Collections

Reduce Yearly Revenue by the cost of billing.

Sample:

$267,750.00/year x 5% = $13,387.50

$267,750.00/year - $13,387.50
= $255,242,50

Revenue Expectations

Average reimbursement occurs within 30-90 days.

Medicare timely filing up to 1 year

Watch contracts – Medicaid, some private payers try to reduce the "timely filing" deadline = Less time to work the claim

Tx Medicaid 90 days

Improve Revenue Cycle

- Low Managed care rates
- Collecting Co-Pays / Co-insurance ahead of the Procedure
- Good documentation = Good coding
- Denial management

Low Managed Care Rates

Who is negotiating contracts?
What is the average contracted rate?
When is the next review of the contracts?
How do the contracted rates benchmark against others?
Are the payers actually paying the negotiated rate?

Allowable Reimbursement

Defined: The maximum dollar amount a third party, usually an insurance company, will reimburse a provider for a specific service.

Allowable Reimbursement $100.00

Sample:

Medicare pays 80%	$80.00
Patient pays 20%	$20.00

Pre-Procedure Collections

Problem: Collecting post-procedure

- Co-Insurance - average 20% or higher
- Health Savings Accounts
- Recession
- Unemployment

Solution:

Collect payments in advance using estimated times.

Documentation

Problem: Poor documentation/Coding

- Increases Denials
- Increases Cost
- Reduces Revenue

Solution:

Good documentation = Good coding

Less Denials

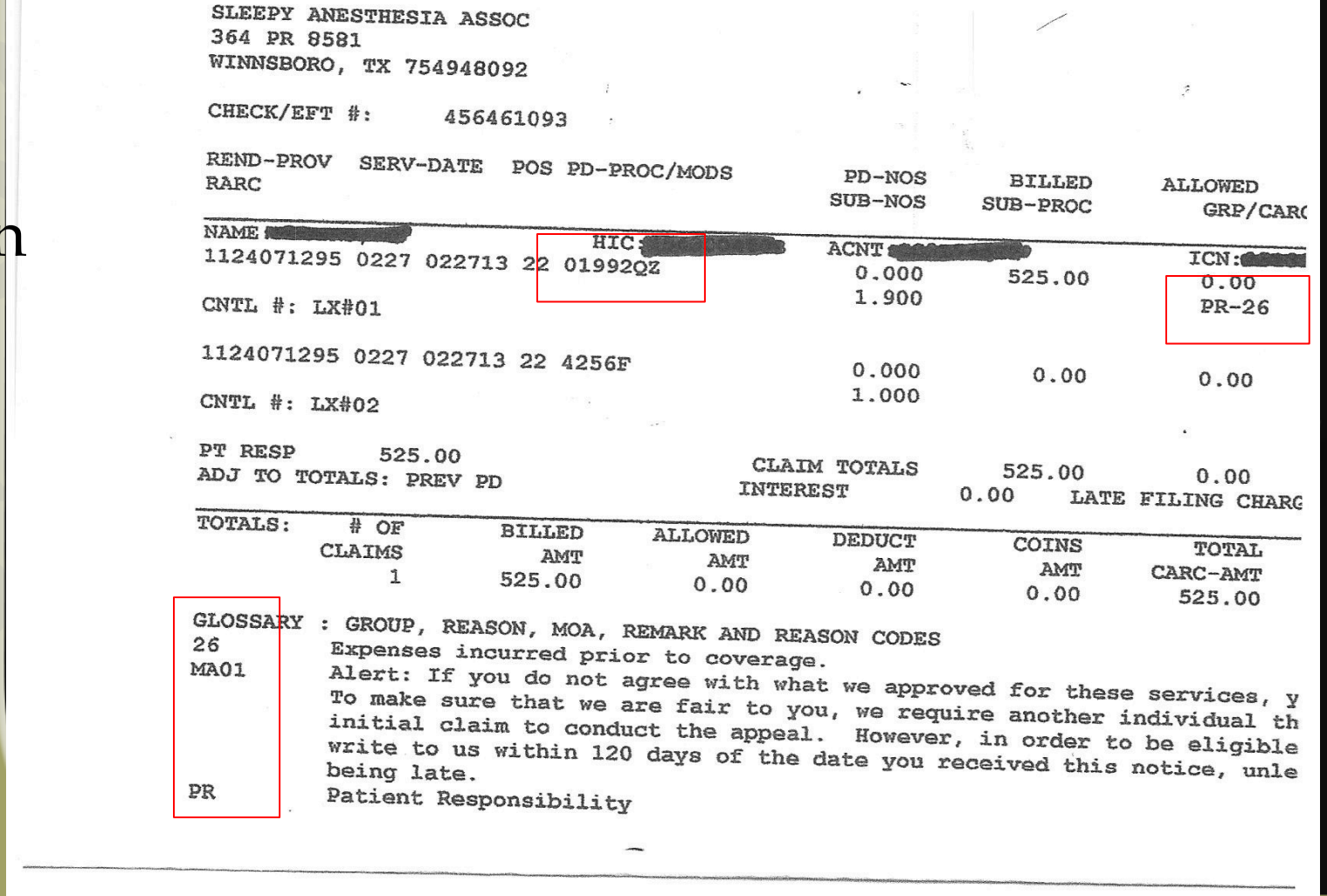
Denials Management

Problem: Claim denied/ incorrect Reimbursement

Solution:

- Review all Explanation of Benefit (EOB)
- Timely Appeal, Appeal, Appeal
- Identify idiosyncrasies of 3rd Party Payers
- Get to know supervisors/document

Sample Explanation of Benefits



SLEEPY ANESTHESIA ASSOC
364 PR 8581
WINNSBORO, TX 754948092

CHECK/EFT #: 456461093

REND-PROV SERV-DATE POS PD-PROC/MODS RARC	PD-NOS SUB-NOS	BILLED SUB-PROC	ALLOWED GRP/CARC
NAME [redacted] HIC: [redacted] ACNT [redacted]			ICN: [redacted]
1124071295 0227 022713 22 01992QZ	0.000	525.00	0.00
CNTL #: LX#01	1.900		PR-26
1124071295 0227 022713 22 4256F	0.000	0.00	0.00
CNTL #: LX#02	1.000		
PT RESP 525.00	CLAIM TOTALS	525.00	0.00
ADJ TO TOTALS: PREV PD	INTEREST	0.00	LATE FILING CHARG

TOTALS:	# OF CLAIMS	BILLED AMT	ALLOWED AMT	DEDUCT AMT	COINS AMT	TOTAL CARC-AMT
	1	525.00	0.00	0.00	0.00	525.00

GLOSSARY : GROUP, REASON, MOA, REMARK AND REASON CODES

26	Expenses incurred prior to coverage.
MA01	Alert: If you do not agree with what we approved for these services, y To make sure that we are fair to you, we require another individual th initial claim to conduct the appeal. However, in order to be eligible write to us within 120 days of the date you received this notice, unle being late.
PR	Patient Responsibility

Balanced Billing vs. Patient Responsibility

Balanced Billing

Billing the balance between the allowable and what you billed

Patient Responsibility

Deductibles and Co-Pays

(fraudulent NOT to attempt to collect patients portion)

Ins. Co. + patients agree on responsibility

Balanced Billing vs. Patient Responsibility

Example: Total Allowable Bill $100.00 ($150.00)

In Network: 80/20 - $100 allowable

Insurance pays:	$80.00
Patient pays:	$20.00

Out of Network: 60/40 (U/C?? - $80)

Insurance pays:	$48
Patient pays:	$32
Balance Bill:	$70

In Network vs. Out of Network

Contracting

Requires:

Research Knowledge

Average Reimbursement

Concept of Top 5

Establish contractual relationships:

Top 5 – Ins. Co. comprising 85-90% of your client base.

Client Relationship

Determine benefit to the contractual agreements:

Group
Facility
Surgeons

In Network

Advantages

Satisfaction – all parties

⇧ Reimbursement

Quicker payment

Less Office follow up

Better $$$ than U/C

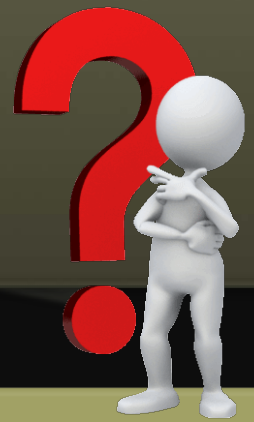
Faster processing – appeals

Disadvantages

Lower $$$ than U/C

Inability to balance bill

Time spent in Negotiations



Out of Network

Advantages

Balance billing

Reduced time negotiating contracts

Some insurance companies pay full

Disadvantages

Balance billing ↓ satisfaction

Lower $$$ in U/C Higher costs to recoup $$$

Agenda

CMS - Medicare

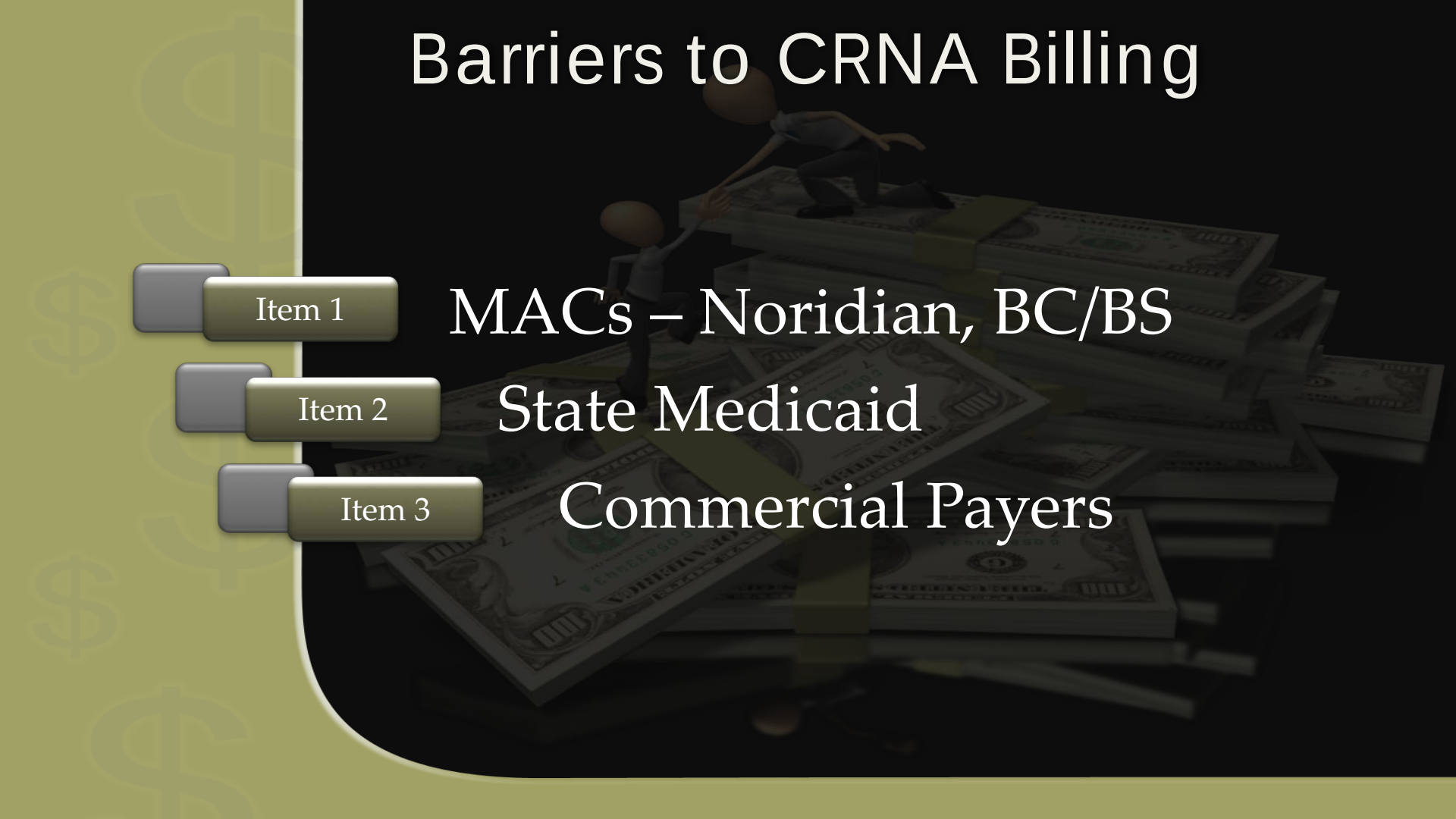
Components of a Bill

Productivity

Billing Costs and Problems

Barriers to CRNA Billing

Barriers to CRNA Billing



- Item 1
- Item 2
- Item 3

MACs – Noridian, BC/BS

State Medicaid

Commercial Payers

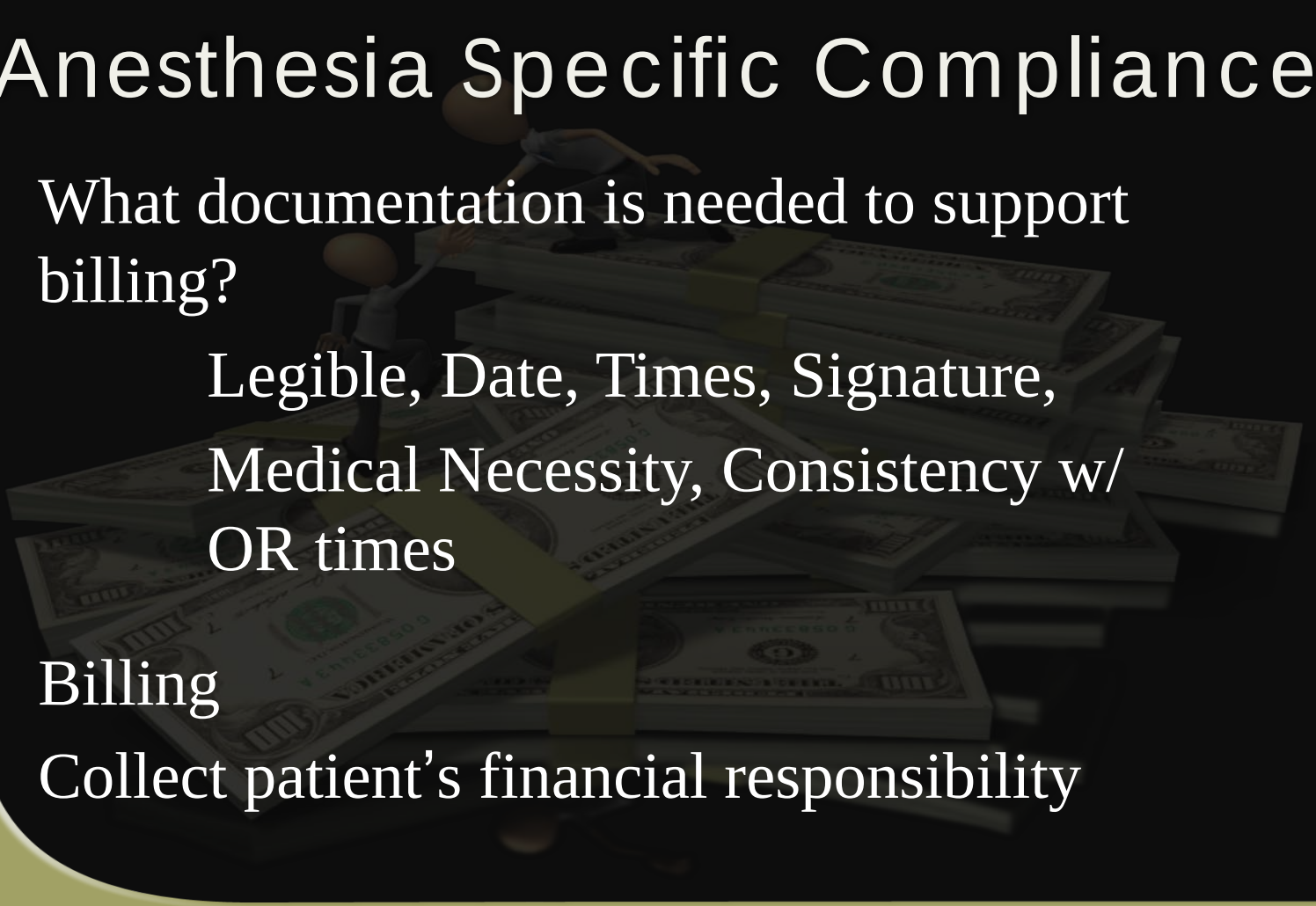
OFFICE OF THE INSPECTOR GENERAL

Carriers perform payment reviews of anesthesiology services:

- Concurrent anesthesiology services
  - Peer practice
  - Experience in review criteria
  - Periodic sampling

Providers may be requested to submit documentation of the names of procedures performed and the names of the anesthetists directed

Anesthesia Specific Compliance



What documentation is needed to support billing?

- Legible, Date, Times, Signature,
- Medical Necessity, Consistency w/ OR times

Billing

Collect patient's financial responsibility

FRAUD HUNTERS

Office of the Inspector General (OIG)
Medicare Administrative Contractors (MACs)
Recovery Audit Contractors (RACs)
Program Safeguard Contractor (PSCs)
Zone Program Integrity Contractors (ZPICs)
Medicaid Integrity Contractors (MICs)

RAC Update

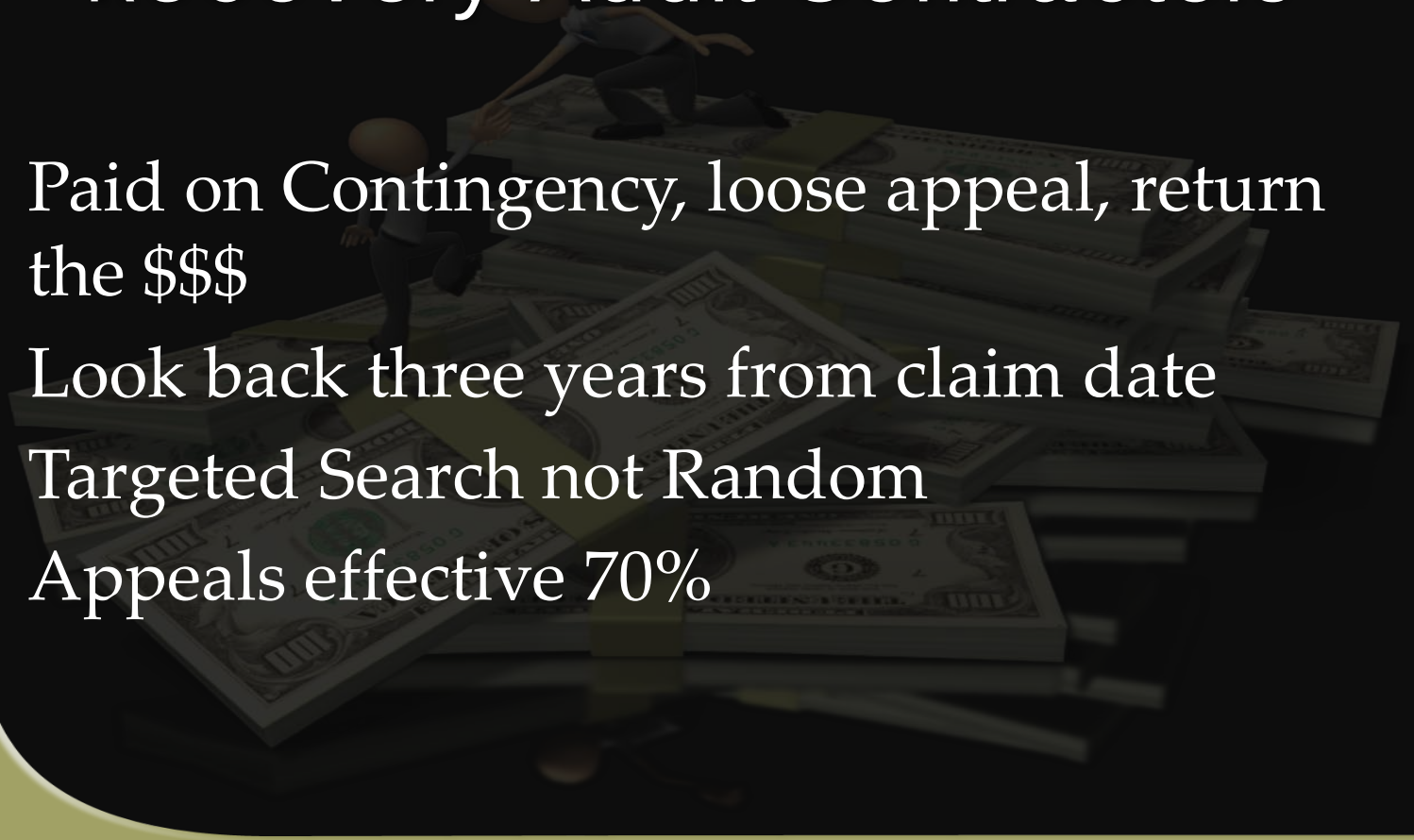
RAC's have recovered over $7B since 2009

RAC audits have an accuracy of 95%
Hospitals responsible for
88% overbilling

Suspension cost ~ $2B for 6months 2014

Recovery Audit Contractors

Highly Cost Effective collecting over 1.3 B - improper payments Costs $0.20 on the dollar



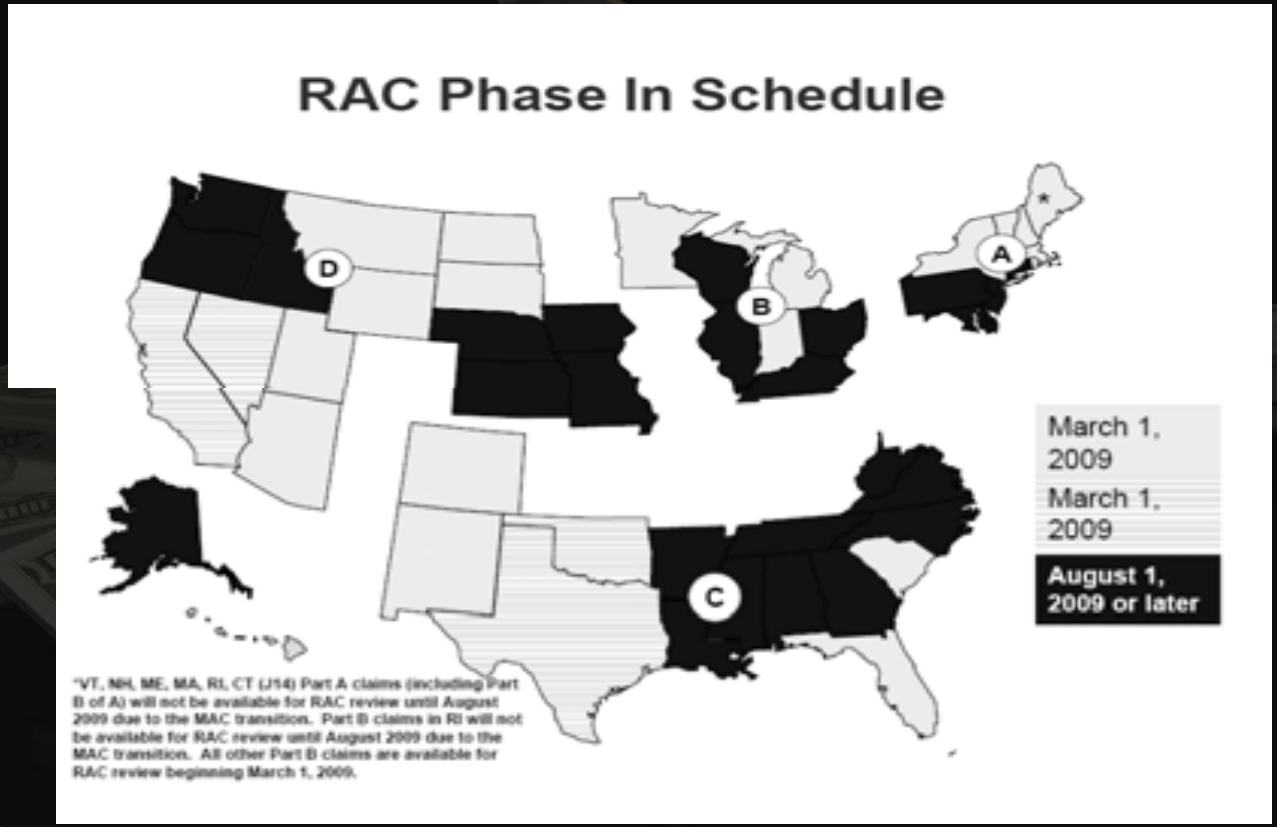
Paid on Contingency, loose appeal, return the $$$

Look back three years from claim date

Targeted Search not Random

Appeals effective 70%

RACs


RAC Phase In Schedule
D
B
A
C
March 1, 2009
March 1, 2009
August 1, 2009 or later
*VT, NH, ME, MA, RI, CT (J14) Part A claims (including Part B of A) will not be available for RAC review until August 2009 due to the MAC transition. Part B claims in RI will not be available for RAC review until August 2009 due to the MAC transition. All other Part B claims are available for RAC review beginning March 1, 2009.

RACs

Region A: Diversified Collection Services (DCS)

States: CT, DE, DC, ME, MD, MA, NH, NJ, NY, PA, RI and VT.

www.dcsrac.com info@dcsrac.com
1-866-201-0580

RACs

Region B: CGI

States: IL, IN, KY, MI, MN, OH and WI

www.racb.cgi.com racb@cgi.com
1-877-316-7222

RACs

Region C: **Connolly Consulting Associates, Inc.**

States: AL, AR, CO, FL, GA, LA, MS, NM, NC, OK, SC, TN, TX, VA, WV, Puerto Rico and US Virgin Islands

www.connollyhealthcare.com/RAC
Email: RACinfo@connollyhealthcare.com
1-866-360-2507

RACs

Region D: HealthDataInsights

States: AK, AZ, CA, HI, ID, IA, KS, MO, MT, ND, NE, NV, OR, SD, UT, WA, WY, Guam, American Samoa, Northern Marianas

www.racinfo.healthdatainsights.com
racinfo@emailhdi.com
Part B 1-866-376-2319

Issues Regions –A,B,C

RAC Update

Cardiovascular Procedures: (Medical Necessity) Medicare pays for inpatient hospital services that are medically necessary for the setting billed. Medical documentation for patients undergoing cardiovascular procedures needs to be complete and sup-port all services provided in the setting billed.

Issues Regions – D

RAC Update

Minor Surgery / treatments billed as Inpatient: (Medical Necessity) When beneficiaries with known diagnoses enter a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital for less than 24 hours, they are considered outpatient for coverage purposes regardless of the hour they presented to the hospital, whether a bed was used, and whether they remained in the hospital after midnight.

Top Anesthesia Issues

RAC Update

- Pain Management
  - Facet Injections, MBB injections
  - ESIs
- Medical Direction
  - Concurrency, Immediately available
  - Use of the AA modifier

Summation

Understand Medicare Processes

Components of a Bill

Determine Productivity

Know Costs of Billing and Hurdles

Improve Revenue Cycles

Questions?

We are happy to help you!

SleepyAnesthesia

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sleepyanesthesia@gmail.com
www.sleepyanesthesia.com

§482.52 Condition of participation: Anesthesia services

CRNA Concern

If the hospital furnishes anesthesia services, they must be provided in a well-organized manner under the direction of a qualified doctor of medicine or osteopathy

All anesthesia services provided in a facility must be organized under one anesthesia service.

§482.52 Condition of participation: Anesthesia services

CRNA Solution

Medical Director does not have to be an anesthesiologist

Policies should reflect anesthesia services in all areas.

§482.52 Condition of participation: Anesthesia services

(a) *Standard: Organization and staffing.* The organization of anesthesia services must be appropriate to the scope of the services offered. Anesthesia must be administered only by—

(1) A qualified anesthesiologist;

(2) A doctor of medicine or osteopathy (other than an anesthesiologist);

(3) A dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under State law;

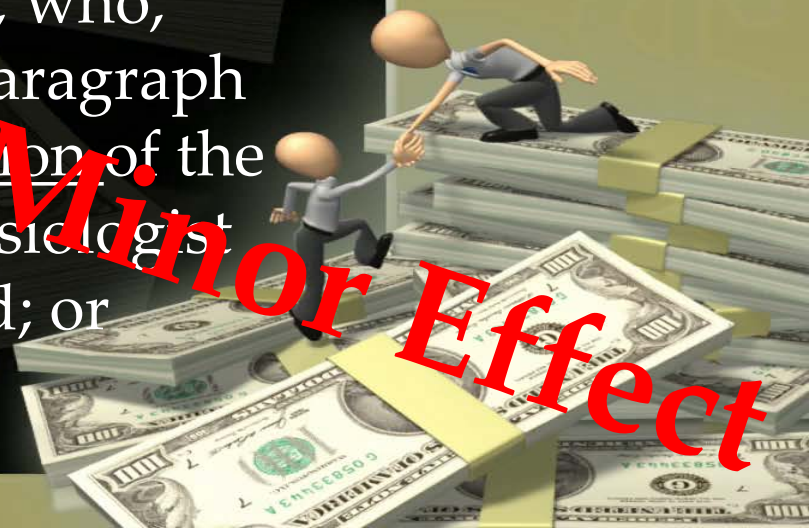
§482.52 Condition of participation: Anesthesia services

(a) Standard: Organization and staffing.

Anesthesia must be administered only by

(4) A certified registered nurse anesthetist (CRNA), as defined in §410.69(b) of this chapter, who, unless exempted in accordance with paragraph (c)of this section, is under the supervision of the operating practitioner or of an anesthesiologist who is immediately available if needed; or

Opt Out



§410.69 Non-physician anesthesia providers

1. Is licensed as a registered professional nurse by the State in which the nurse practices;
2. Meets any licensure requirements the State imposes with respect to non-physician anesthetists;
3. Has graduated from a nurse anesthesia educational program
4. meets the following criteria
   pass certification exam within 24 months of 3.

CRNA

6/29/2009 update

§482.52 Condition of participation: Anesthesia services

Supervision defined

"Hospitals should conform to generally accepted standards of anesthesia care when establishing policies for supervision by the operating practitioner."

Individual operating practitioners do not need to be granted specific privileges to supervise a CRNA

§482.52 Condition of participation: Anesthesia services

Immediately available defined

… if he/she is physically located within the same area as the CRNA, e.g. in the same operative procedural suite, or in the same labor and delivery unit, and not otherwise occupied in a way that prevents him/her from immediately conducting hand- on intervention, if needed.

§482.52 Condition of participation: Anesthesia services

Regional Anesthesia

Labor and Delivery

The administration of medication via an epidural or spinal route for the purpose of analgesia, during labor and delivery is not considered anesthesia and therefore is not subject to the anesthesia supervision requirement.

If the patient proceeds to C-section then supervision applies.

5/21/2010 update

§482.52 Condition of participation: Anesthesia services

(5) An anesthesiologist's assistant, as defined in §410.69(b) of this chapter, who is under the supervision of an anesthesiologist who is immediately available if needed.

Same definition supervision and immediately available.

Does not say Medically Directed

AA's

AA's ≠ Billing QZ

While AA's may work in a supervisory capacity - cannot bill QZ

If used in this capacity must bill AD

Disincentive

CMS
Mcare
Part B

No

140 - Certified Registered Nurse Anesthetist Services (Rev. 1, 10-01-03)

B3-16003, B3-16003 A, B3-3040.4, B3-4172

Section 9320 of OBRA 1986 provides for payment under a fee schedule to certified registered nurse anesthetists (CRNAs) and anesthesia assistants (AAs). CRNAs and AAs may bill Medicare directly for their services or have payment made to an employer or an entity under which they have a contract. This could be a hospital, physician or ASC. … effective for services rendered on or after January 1, 1989.

Anesthesia services: subject to Part B coinsurance and deductible and when furnished on or after January 1, 1992…. Payment for CRNA services is made only on an assignment basis.

Medicare Claims Processing Manual, Chapter 12, section 140

140.3 - Anesthesia Fee Schedule Payment for Qualified Nonphysician Anesthetists

(Rev. 2716, Issued: 05-30-13, Effective:01-01-13, Implementation: 02-12-13)

NO

Pay for the services of a qualified nonphysician anesthetist only on an assignment basis. The assignment agreed to by the qualified nonphysician anesthetist is binding upon any other person or entity claiming payment for the service.

Medicare Assignment

?

"Meaning of **Assignment** - For purposes of this agreement, accepting **assignment** of the Medicare Part B payment means requesting direct Part B payment from the Medicare program. Under an **assignment**, the approved charge, determined by the Medicare carrier, shall be the full charge for the service covered under Part B. The participant shall not collect from the beneficiary or other person or organization for covered services more than the applicable deductible and coinsurance."
(http://www.instacode.com/assignment - 11/05/2013)

140.1 – Qualified Non-physician Anesthetist

(Rev. 2716, 05-30-13) Effective: 01-01-13, Imp: 02-12-13

AA

permitted by State law to administer anesthesia;
Has successfully completed a six-year program for AAs of which two years consist of specialized academic and clinical training in anesthesia.

NO

CRNA

currently certified - Council on Cert.. or the Council on Recert, or
Has graduated within the past 18 months from a NAP that meets the standards of the COA and is awaiting initial certification.

140.2 - Entity or Individual to Whom Fee Schedule is Payable for Qualified Nonphysician Anesthetists

(Rev. 2716, Issued: 05-30-13, Effective:01-01-13, Imp: 02-12-13)

NO

Payment for the services of a qualified nonphysician anesthetist may be made to the qualified nonphysician anesthetist who furnished the anesthesia services or to a hospital, physician, group practice or ASC with which the qualified nonphysician anesthetists has an employment or contractual relationship.

140.3.1 - Conversion Factors Used on or After January 1, 1997 for Qualified Nonphysician Anesthetists (Rev. 2716, Issued: 05-30-13, Effective:01-01-13, Implementation: 02-12-13)

NO

The conversion factors applicable to the anesthesia services furnished on or after 1/1/1997, are increased by the update factor used to update physicians' services under the physician fee schedule. The are published in November of the year preceding the year in which they apply.

140.3.4 - General Billing Instructions

(Rev. 2716, Issued: 05-30-13, Effective:01-01-13, Implementation: 02-12-13)

Same as MDA

All claims forms must have the provider billing number of the CRNA, AA and/or the employer of the qualified nonphysician anesthetist performing the service..

NO

CRNAs identified by specialty code 43
AAs identified by specialty code 32

140.5 - Payment for Anesthesia Services Furnished by a Teaching CRNA

(Rev. 1859; Issued: 11-20-09; Effective: 01-01-10; Imp: 01-04-10)

NO

Payment can be made under Part B to a teaching CRNA who supervises a single/two case(s) involving a student nurse anesthetist where the CRNA is continuously present. The CRNA reports the service using the usual "QZ" modifier. This modifier designates that the teaching CRNA is **not** medically directed by an anesthesiologist. No payment is made under Part B for the service provided by a student nurse anesthetist.