CBR201705:
Anesthesia Services for
Lower Endoscopic Procedures
Webinar Questions & Answers

July 12, 2017
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INTRODUCTION

These questions are excerpted from the CBR201705: Anesthesia Services for Lower Endoscopic Procedures webinar presented on Wednesday, July 12, 2017. You have the option to view the entire recording of the comparative billing report (CBR), listen to the audio-only version or view the webinar text. You may also open a PDF of the slides or select a specific section of the webinar. All of these options are available from the CBR website page titled CBR201705 Webinar (https://www.cbrinfo.net/cbr201705-webinar).

The CBR project has made every reasonable effort to ensure the accuracy of the information and web links provided in the CBR materials at the time of publication; however, Medicare policy changes frequently, so the information and links within the material may change without further notice. It is the responsibility of the provider to remain up-to-date with Medicare program requirements.

CBR materials are prepared as a service to the public and are not intended to grant rights or impose obligations. The information provided in the CBR is only intended to be a general summary. It does not supersede or alter the coverage and documentation policies outlined in the Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and National Coverage Determinations (NCDs) for the Medicare Administrative Contractors (MACs) or Durable Medical Equipment Medicare Administrative Contractors (DME MACs). All coverage and documentation policies are located on the Centers for Medicare & Medicaid Services (CMS) website on the page titled Medicare Coverage Database (https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx).

Please refer any specific questions you may have to the MAC or DME MAC for your region. We encourage providers to review the specific statutes, regulations, and other interpretive material for a full and accurate statement of their contents. A listing of all MACs can be accessed from the website of CMS at the following link: Review Contractor Directory – InteractiveMap (http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).
**GENERAL**

**Q. Can I receive continuing education units (CEUs) for attending a CBR webinar?**
A. CMS does not offer CEUs for attending CBR webinars at this time, but you may receive CEUs from some other organizations. For more information about CEUs, log on to the CMS website at the following link: [Continuing Education Credits](https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/Continuing-Education.html).

**Q. Will I be audited since I received a CBR?**
A. The CBR is for informational and educational purposes and is not considered an audit. The CBR team does not perform any audits, nor do we have access to medical charts used for audit purposes; however, we do have resources on the CBR website that may be helpful with setting up a self-audit process. To view this information, select the following link: [Self-Audit Help](http://www.cbrinfo.net/self-audit-help.html).

**Q. Will Medicare request money back if it’s determined that our claims were billed inappropriately?**
A. If you believe you have billed claims inappropriately, you should conduct a self-audit and disclose this information to your MAC. Please contact your MAC for appropriate steps to take to correct your claims. Contact information for your MAC can be found at [Review Contractor Directory – Interactive Map](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).

**Q. Who has access to my CBR letter?**
A. Each CBR is private and is sent only to the individual provider. It is not shared with the general public. Although each CBR is not available to anyone other than the provider, CMS is made aware of the recipients and the data used may be shared with CMS at their request.
Q. Is the information in this webinar applicable to all regions?
A. The data used in CBR201705 was pulled from the national database for all Medicare Part B providers in all regions and states. Each provider is then compared to providers in his/her state and the nation overall. This webinar addresses all providers covered in the CBR, regardless of location.

CLINICAL AND BILLING

Q. Is a deductible required for colonoscopy screening for Medicare patients?
A. Beginning January 1, 2015, the deductible and coinsurance for anesthesia (CPT® code 00810) services for colonoscopy screenings were waived (per mandate by the Affordable Care Act) for services performed in conjunction with Healthcare Common Procedural Coding System (HCPCS) codes G0105 or G0121; however, modifier 33 must be added to Current Procedural Terminology (CPT®) code 00810 for the waiver to apply. If claims are submitted without modifier 33, patients will be responsible for deductibles and coinsurance. If you’d like more information, see the MLN Matters publication (Number: MM8874) at this web link: Preventive and Screening Services — Update - Intensive Behavioral Therapy for Obesity, Screening Digital Tomosynthesis Mammography, and Anesthesia Associated with Screening Colonoscopy (https://www.cms.gov/Outreach-and-education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8874.pdf).

Q. If a colonoscopy screening changes to a diagnostic procedure, should modifiers 33 and PT be reported?
A. Anesthesia providers should bill CPT® code 00810 when submitting claims for anesthesia for lower intestinal endoscopic procedures, with the endoscope introduced distal to the duodenum. If the screening colonoscopy becomes a diagnostic colonoscopy, modifier PT should be reported and the deductible will be waived. To view more information about waiver of deductibles, select the following web link: Medicare Claims Manual, Chapter 18, Section 1.2 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c18.pdf).
Q. Along with appending either modifier 33 or PT, does the screening (ICD-10) code factor in regular screening Z12.11 vs. high risk colon cancer screening codes?

A. CBR201705 focused on Medicare Part B providers with allowed anesthesia service claims with CPT® code 00810 for lower endoscopic procedures. We did not specifically review claims with ICD-10 code Z12.11 (Cologuard Multitarget Stool DNA Test) nor any other specific diagnoses. We suggest that you contact your MAC with questions pertaining to ICD-10 code Z12.11. To locate your MAC, select the following link: [Review Contractor Directory – InteractiveMap](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).

Q. Does Medicare require the patient status modifier (P1 - P6) or modifier QS?

A. Modifiers P1 – P6 are physical status modifiers and are not used by Medicare. The QS modifier is for monitored anesthesia care. Per Chapter 12 of the Medicare Claims Processing Manual: “The QS modifier can be used by a physician or a qualified nonphysician anesthetist and is for informational purposes. Providers must report actual anesthesia time and one of the payment modifiers on the claim.” This information is found at the link titled [Medicare Claims Processing Manual, Chapter 12, Section 140.3.3](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf).

Q. CMS has been looking at CPT® codes 00810 and 00740 as mis-valued codes. Do you foresee the base value being decreased from 5 units in 2018?

A. Section 3134(a) of the Affordable Care Act (ACA) requires a review periodically to identify potentially mis-valued services and to review and make appropriate adjustments to the relative values for those services. To review more details, select this web link: [Affordable Care Act, Section 3134(a)](https://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf).
Q. What documentation do you need when the surgeon has requested general anesthesia for these procedures?

A. Medicare pays for anesthesia when the documentation supports medical necessity. Documentation should include a pre-anesthetic evaluation and exam, the anesthesia prescription, including medications and postoperative anesthetic care. Per Novitas Solutions LCD L35049: “Reimbursement for MAC will be the same amount allowed for full general anesthesia services if all requirements listed under these indications are met. The provision of quality MAC is mandatory and requires the same expertise and the same effort (work) as required in the delivery of a general anesthetic. If the requirements are not fulfilled or the procedures are unnecessary, payment will be denied in full.” For additional information, select the following web link: Novitas LCD L35049 ([https://www.cms.gov/medicare-coverage-database/details/lcddetails.aspx?LCDId=35049&ver=30&Date=10%2f01%2f2015&DocID=L35049&bc=iAAAAABAAIAAAAA%3d%3d&](https://www.cms.gov/medicare-coverage-database/details/lcddetails.aspx?LCDId=35049&ver=30&Date=10%2f01%2f2015&DocID=L35049&bc=iAAAAABAAIAAAAA%3d%3d&)).

Q. Could you go over the use of modifier 51 for multiple procedures? Our claims are denied when we file them with modifier 51.

A. According to instructions in Chapter 12 of the Medicare Claims Processing Manual, “Physicians bill for the anesthesia services associated with multiple bilateral surgeries by reporting the anesthesia procedure with the highest base unit value with the multiple procedure modifier-51. They report the total time for all procedures in the line item with the highest base unit value.” To see information about multiple procedures, select this web link: Medicare Claims Processing Manual, Chapter 12, Section 40.6-40.7 ([https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf)).

We are aware that several MACs recommend that you do not append modifier 51. Information in the CBR is intended to be a general summary and doesn’t supersede or alter the coverage and documentation policies outlined in the LCDs and LCAs for the A & B or DME Medicare Administrative Contractors. For specific questions about coverage and billing, please contact the MAC for your region, which you can find at the following link: Review Contractor Directory – InteractiveMap ([http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/](http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/)).
Q. Since CPT® code 00810 carries 5 base units, if anesthesia time is 2 units, would you report 7 total units on a claim or just 2?
A. Anesthesia time is reported in minutes on claim form CMA-1500 and begins when the provider starts preparing the patient for induction of anesthesia. Hours are converted to minutes and reported in Item 24G of the claim form or the equivalent electronic media claim (EMC) field. Your MAC will then compute the time units by dividing reported time by 15 minutes. The time units are rounded to one decimal place. For more information, select the following link: Medicare Claims Processing Manual, Chapter 26, Section 10.4 (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c26.pdf).

Q. We are often requested by GI doctors to provide anesthesia for patients having both a screening colonoscopy and EGD on the same date of service. Since they both have the same base units, which code do you suggest we use to bill?
A. They both have a base unit of 5 so it would not matter which code you billed. For more information on billing anesthesia services, please visit the following website: Anesthesiologists Center (https://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center.html).

Q. When anesthesia claims are submitted "without" colonoscopy, how do you expect anesthesia to control the surgeon’s billing habits or the facility bills?
A. This measure was selected in order to determine if providers were submitting claims for CPT® code 00810 without corresponding colonoscopy services allowed on the same day. You should ensure that your documentation supports that the service was provided and meets the criteria for payment. The CBR team understands that the anesthesia provider has no control over the colonoscopy claims that may have been billed incorrectly or may have been denied. The purpose of the CBR is to provide comparative data on how an individual health care provider’s billing and payment patterns compare to those of their peers. The CBR is solely for provider and supplier information and education. The report supplies providers with an opportunity to compare themselves to their peers, check their records against data in CMS files, and review Medicare guidelines to ensure compliance.
Q. Where can I see the type of data reports assembled for this webinar?
A. The webinar is based on the actual data used in the CBR. The webinar examples utilized the data of a mock provider whose example report can be found on the website, www.cbrinfo.net. The sample has examples of each of the metrics used in the report, the methodologies used, and table examples. Also on the website, the statistical debriefing summarizes all of the percentages and averages for the metrics for each state and the nation. For more information, select the following web link: CBR201705 Statistical Debriefing (https://www.cbrinfo.net/cbr201705-statistical-debriefing).

Q. How was it determined which providers would receive CBRs?
A. There are over 65,000 providers nationwide with allowed charges for CPT® code 00810 that are included in this study. Those who received the CBR were significantly higher than one of their peer groups on at least one of the measurements studied and also were above the 75th percentile in allowed charges ($5,000), with at least 19 beneficiaries during this one-year period. The CBR was sent to approximately 8,000 providers of anesthesia. Providers who did not receive CBR letters can review a sample on our website at the link, CBR201705 Sample CBR (https://www.cbrinfo.net/cbr201705-sample-cbr).

Q. Will you rerun reports to distinguish between MD only groups and team care so AA modifier, which is significantly higher, is not considered abnormal?
A. The purpose of the CBR is to provide comparative data on how an individual health care provider’s billing and payment patterns compare to those of their peers. The CBR is solely for provider and supplier information, and they give providers an opportunity to compare themselves to their peers, check their records against data in CMS files, and review Medicare guidelines to ensure compliance. CBRs are not punitive. No medical records were reviewed as part of this process, and no overpayments have been identified.

The percentage of visits appended with modifier AA was chosen as one of the metrics in this CBR to identify potential overutilization because of the 100 percent reimbursement rate. In
calculating the percentage of visits appended with modifier AA, the national and state percentages are based only on those claim lines where the rendering specialty is a physician. However, each individual provider (regardless of the specialty) was compared to those peer values. The national percentage for this metric was 47 percent.

The CBR team is aware that practice patterns differ for various reasons, including geographic location and patient acuity levels. Some practitioners have sub-specialties or distinctive focuses that aren’t apparent in claims data. Other providers practice in rural or under-served, urban areas where they may see a higher proportion of sicker Medicare beneficiaries. If those sound like characteristics of your practice, the results of the CBR letter may not be surprising. If, on the other hand, your CBR shows your utilization differs significantly from your peers and you don’t know why that would be the case, you may want to choose a few charts that are representative of your normal utilization and perform a self-audit. If interested in resources to assist with setting up an audit process, please visit our CBR website at the link titled, Self-Audit Help (https://www.cbrinfo.net/self-audit-help.html).

Q. How will these reports be used in the future as the data is filled with incomplete data? Did you look at ICD-10 codes with data to identify patterns of time and type of comorbidities? Did you look at type of anesthesia and time for patterns of time?

A. The focus of CBR201705 is to compare the billing patterns of providers with allowed anesthesia claims with CPT® code 00810 for lower endoscopic procedures. This procedure was selected for a CBR because it ranks in the top 20 service types with the highest rate of improper payments for Medicare Part B services. Please remember that the purpose of the CBR is to provide comparative data on how an individual health care provider’s billing and payment patterns compare to those of their peers. Additionally, the CBR is solely for provider and supplier information, and they give providers an opportunity to compare themselves to their peers, check their records against data in CMS files, and review Medicare guidelines to ensure compliance. All statistics supplied in this general analysis are based only on the information obtained from the claims. No additional documentation was reviewed, nor special circumstances or diagnoses considered when making these calculations. If interested in seeing the results of the analyses for each state and the nation, please select the following web link: CBR201705 Statistical Debriefing (https://www.cbrinfo.net/cbr201705-statistical-debriefing).
Q. Since anesthesia time is largely based on the surgeon/procedure time, how are they being targeted for extended times if the GI docs are doing an upper and lower at the same time but the claim goes out with CPT® codes 00810 instead of 00740? Both have the same base unit value but the time is really for two procedures. How did the analysis take this into account?

A. This CBR letter does not indicate any wrong-doing and is meant for educational purposes based on the literature included in the references and resources section of this CBR. The report is a comparative analysis. The CBR team is aware that practice patterns differ for various reasons, including geographic location and patient acuity levels. Some practitioners have sub-specialties or distinctive focuses that aren’t apparent in claims data. Other providers practice in rural or under-served, urban areas where they may see a higher proportion of sicker Medicare beneficiaries. If those sound like characteristics of your practice, the results of the CBR letter may not be surprising. If, on the other hand, your CBR shows your utilization differs significantly from your peers and you don’t know why that would be the case, you may want to choose a few charts that are representative of your normal utilization and perform a self-audit. For resources to help with setting up an audit process, please visit our CBR website at this link: Self-Audit Help (https://www.cbrinfo.net/self-audit-help.html).

Q. So if we did not receive the CBR, would that mean none of our providers met the threshold, which is a good thing, right?

A. After analyzing all of the data for each individual provider, we chose those providers that were Significantly Higher than their peers in at least one of the three metrics described in CBR201705. Additionally, each of these providers met certain thresholds of allowed charges and beneficiary counts that depend on the universe of providers. For this CBR, recipients had at least $5,000 in allowed charges and at least 19 beneficiaries. These thresholds are at about the 75th percentile of all providers of CPT® code 00810, and were chosen to ensure that the providers had sufficient information to compare to the peer groups, and that they could benefit from the educational material supplied in this letter. If you did not receive a CBR, we would suggest a self-audit so that you can compare your billing patterns to the state and national levels. If interested in seeing the results of the analyses for each state and the nation, please select the following web link: CBR201705 Statistical Debriefing (https://www.cbrinfo.net/cbr201705-statistical-debriefing).
Q. What is the percentage used to determine that services are significantly higher?
A. Unfortunately, there is not a specific percentage that would determine significance. The statistical tests used account for variations within each provider’s billings, such as the total number of services allowed during this time period, and the variability of the data when comparing averages. I encourage you to seek more information on the chi-square and t-tests to have a better understanding of how significance is determined. For an explanation of the chi-square and t-test, please visit the University of Connecticut website at http://researchbasics.education.uconn.edu/anova_regression_and_chi-square/.

Q. On Table 4, we have visits without colonoscopy (6) with total number of visits (166). Does this mean we used the code improperly? Do you consider a non-matching claim if the physician bills with a modifier different than the anesthesia claim? For the missing colonoscopy, did you only look at the anesthesia date billed or did you look at a range of dates to catch service date errors?
A. Table 4 is the results of the analysis of the Percentage of Visits without an Allowed Colonoscopy Claim. Medicare Part B claims were searched for colonoscopy services CPT® codes 45300-45398, G0105, and G0121. Any beneficiary that did not have an allowed service for one of these CPT®/HCPCS codes on the actual date of service of the anesthesiology service, that service was flagged as a visit without an allowed colonoscopy claim. The national percentage for this metric was 4 percent. There may be legitimate reasons why the colonoscopy claim was not found in the claims database, such as a billing error or nonpayment. The point of the CBR is to compare your billings with those of your peers. The percentage of visits without an allowed colonoscopy claim for each state and the nation on our CBR website at the page titled CBR201705 Statistical Debriefing (https://www.cbrinfo.net/cbr201705-statistical-debriefing).
REFERENCES

CBR201705 Webinar (https://www.cbrinfo.net/cbr201705-webinar)


Self-Audit Help (http://www.cbrinfo.net/self-audit-help.html)


Affordable Care Act, Section 3134(a) (https://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf)


Anesthesiologists Center (https://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center.html)

CBR201705 Statistical Debriefing (https://www.cbrinfo.net/cbr201705-statistical-debriefing)