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CBR201705: Anesthesia Services for Lower Endoscopic Procedures

July 12, 2017
3:00 P.M. ET
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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 material 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) and Local Coverage Articles (LCAs) for the A/B Medicare Administrative Contractors (MAC) or DME Medicare Administrative Contractors (DME MAC). Please refer any specific questions you may have to the A/B 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.
1. Introduction
2. Coverage & Documentation Overview
3. Methods & Results
4. References & Resources
5. Q&A
6. Survey
Webinar Protocol

- All attendee lines are muted
- Submit questions via chat when prompted by speaker
- Submit questions during the Q&A session at the end of webinar
- Ask questions pertinent to webinar
- Contact MAC for specific claims questions
Upon completion of this webinar, you should be able to:

- Demonstrate a general understanding of CBR201705: Anesthesia Services for Lower Endoscopic Procedures
- Comprehend the analytical methods used to develop the report
- Locate policy references and resources
CBR201705: Anesthesia Services for Lower Endoscopic Procedures
http://www.cbrinfo.net/cbr201705-sample-cbr
CBR Purpose & Focus

- Average time units appended per visit
- Percentage of visits billed without an allowed colonoscopy claim
- Percentage of visits appended with modifier AA
- Approximately 8,000 providers
Webinar Materials

- References and Resources
- Webinar slides
- MP4 of webinar
- Webinar Handout
- Webinar Q&A Handout
## Acronyms

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACA</td>
<td>Affordable Care Act</td>
</tr>
<tr>
<td>CBR</td>
<td>Comparative Billing Report</td>
</tr>
<tr>
<td>CERT</td>
<td>Comprehensive Error Rate Testing</td>
</tr>
<tr>
<td>CPT®</td>
<td>Current Procedural Terminology</td>
</tr>
<tr>
<td>CRNA</td>
<td>Certified Registered Nurse Anesthetist</td>
</tr>
<tr>
<td>HCPCS</td>
<td>Healthcare Common Procedure Coding System</td>
</tr>
<tr>
<td>LCA</td>
<td>Local Coverage Article</td>
</tr>
<tr>
<td>LCD</td>
<td>Local Coverage Determination</td>
</tr>
<tr>
<td>MAC</td>
<td>Medicare Administrative Contractor</td>
</tr>
<tr>
<td>NPI</td>
<td>National Provider Identifier</td>
</tr>
<tr>
<td>NPP</td>
<td>Non-Physician Practitioner</td>
</tr>
<tr>
<td>OIG</td>
<td>Office of Inspector General</td>
</tr>
</tbody>
</table>
Coverage & Documentation Overview

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Colonoscopy screenings are considered preventive services:

- Waives coinsurance and deductibles
- Covers moderate sedation
OIG 2013 Work Plan included Part B claims:

- For personally performed anesthesia services
- To determine if providers are billing anesthesia modifiers correctly
U. S. Food & Drug Administration (FDA) Office of Criminal Investigations:

- April 2, 2015: Former Owner of Las Vegas Endoscopy Center, Dipak Desai, M.D., Pleads Guilty to Federal Health Care Fraud Charges:
  - Overstated amount of time provided for anesthesia procedures
CERT Reports

Medicare Fee-for-Service Improper Payments Report (CERT) Findings:

- **2015**
  - Anesthesia in top 20 for payment errors
  - $241 million in improper payments
  - Insufficient documentation
  - Incorrect coding

- **2016**
  - Payment errors reduced
  - $59 million in improper payments
Widespread Review Anesthesia for Lower Intestinal Endoscopic Procedures First Quarter of FY 2017:

- Top denial reasons for CPT® 00810:
  - No response to Additional Documentation Requests (ADR)
  - Insufficient/illegible documentation
  - Provider signature missing or illegible
Anesthesia involves the administration of a medication to produce a blunting or loss of:

- Pain perception (analgesia)
- Voluntary and involuntary movements
- Autonomic function
- Memory and/or consciousness
Monitored anesthesia care involves the intra-operative monitoring by a physician or qualified individual under the medical direction of a physician or of the patient’s vital physiological signs in anticipation of the need for administration of general anesthesia or of the development of adverse physiological patient reaction to the surgical procedure.
“Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to the duodenum”
Monitored Anesthesia Care

Local Coverage Determinations (LCDs)

<table>
<thead>
<tr>
<th>Medicare Administrative Contractor</th>
<th>Current</th>
<th>Retired</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Coast Service Options, Inc.</td>
<td>L33595</td>
<td>L30561</td>
</tr>
<tr>
<td>Noridian Healthcare Solutions, LLC</td>
<td>L34100</td>
<td>L24332</td>
</tr>
<tr>
<td>Novitas Solutions, Inc.</td>
<td>L35049</td>
<td>L32628</td>
</tr>
</tbody>
</table>

Title 42 - Public Health, Section 410.69, Services of a certified registered nurse anesthetist (CRNA) or anesthesiologist’s assistant - Basic Rule:

Medicare Part B pays for anesthesia services and related care furnished by a certified registered nurse anesthetist or an anesthesiologist's assistant who is legally authorized to perform the services by the State in which the services are furnished.
CRNA Exemption

Anesthesia supervision exemption:

- CMS established exemption for CRNAs from physician supervision requirement in 2001
- Guam and 17 states have chosen to opt-out of CRNA physician supervision
- Requires a Governor’s written request
Preventive Modifiers

**Modifier 33:**
- Preventive service
- Appended to CPT® when billed with HCPCS codes G0105 or G0121

**Modifier PT:**
- Screening colonoscopy resulting in diagnostic procedure
- Appended in second modifier position
# Modifiers Frequently Used with Anesthesia Services

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA</td>
<td>Anesthesia personally performed by physician</td>
</tr>
<tr>
<td>AD</td>
<td>Supervision of more than 4 procedures by physician</td>
</tr>
<tr>
<td>QK</td>
<td>Medical direction of 2, 3, or 4 procedures</td>
</tr>
<tr>
<td>QX</td>
<td>Medical direction of qualified non-physician anesthetist</td>
</tr>
<tr>
<td>QY</td>
<td>Medical direction of one qualified non-physician anesthetist</td>
</tr>
<tr>
<td>QZ</td>
<td>Qualified non-physician anesthetist performs without medical direction</td>
</tr>
<tr>
<td>PT</td>
<td>Colonoscopy screening converted to diagnostic procedure</td>
</tr>
<tr>
<td>33</td>
<td>Preventive service</td>
</tr>
<tr>
<td>76</td>
<td>Repeat procedure by same physician or qualified health care professional</td>
</tr>
</tbody>
</table>
**Guidelines:**

- Continuous monitoring from start to finish
- Begins with preparation for induction
- Ends when patient is placed under post-op supervision
- Practitioner is present with patient
Anesthesia Time Units

Guidelines:

- Report actual anesthesia time in minutes
- Convert hours into minutes
- Divide hours by 15 to get billable units
Anesthesia Payment

Reimbursement made according to:

- Base units assigned to anesthesia CPT® codes by CMS
- Conversion Factor (CF) is released by CMS annually

Formula to calculate time:

- \[[\text{Base units} + \text{Time (in units)}] \times \text{CF} = \text{Anesthesia Fee Amount}\]
Billing Multiple Procedures

Guidelines for two or more procedures:

- Report anesthesia procedure with the highest base unit
- Submit anesthesia code with modifier 51
- Include total anesthesia time in minutes
Requirements:

- Name and beneficiary identification
- Anesthesia start and stop times
- Order or documentation of drugs
- Name and signature of provider
Payment Conditions:

- The physician personally performed the entire anesthesia service alone.
- The physician is involved with one anesthesia case with an intern or resident.
- The physician is continuously involved in a single case involving a student nurse anesthetist.
- The physician is continuously involved in one anesthesia case involving a CRNA or anesthesiologist assistant.
- The physician and the CRNA or anesthesiologist assistant are involved in one anesthesia case and the services of each are found to be medically necessary. Documentation must be submitted by both the CRNA and the physician to support payment of the full fee for each of the two providers.
Medically Directed Rate

Payment Conditions:

- Perform pre-anesthetic evaluation
- Prescribe the plan
- Personally participate in induction and emergence if needed
- Monitor the qualified anesthetist
- Remain physically present and available
Medically Supervised Rate

Payment Conditions:

- Allow three base units per procedure
- Physician involved in more than four procedures concurrently
- Physician performing services while directing concurrent procedures
- Additional time unit may be billed if anesthesiologist is present at induction
Methods & Results
Medicare Part B *Rendering* Providers:

- By National Provider Identifier (NPI)
- CPT® Code 00810
- Extracted: April 13, 2017 from Integrated Data Repository (IDR)
- Dates of Service: January 1, 2016 – December 31, 2016
### Table 1: Modifiers Frequently Used with Anesthesia Services

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<td>76</td>
<td>Repeat Procedure by same physician or qualified health care professional</td>
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</tbody>
</table>
Table 2: Summary of Your Utilization of CPT® Code 00810
January 1, 2016 – December 31, 2016

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Allowed Charges</th>
<th>Allowed Services</th>
<th>Visit Count</th>
<th>Beneficiary Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>00810</td>
<td>$13,368</td>
<td>83</td>
<td>83</td>
<td>82</td>
</tr>
</tbody>
</table>
Metrics and National Statistics

- Average Number of Time Units Appended per Visit
  - Nation: 2.27

- Percentage of Visits Billed without an Allowed Colonoscopy Claim (CPT® 45300-45398, G0105, G0121)
  - Nation: 4%

- Percentage of (Physician) Visits with Modifier AA
  - Nation: 47%
Peer Groups

- Used for comparison with the individual providers

State

- Rendering Medicare providers in the provider’s state billing CPT® Code 00810

National

- All rendering Medicare providers in the nation billing CPT® Code 00810
Comparison Outcomes

There are four possible outcomes:

1. Significantly Higher
2. Higher
3. Does Not Exceed
4. N/A
Average Number of Time Units Appended per Visit

Calculated as follows:

\[
\frac{\text{Total Time Units}}{\text{Total Number of Visits}}
\]
Table 3

Table 3: Average Time Units Appended per Visit
January 1, 2016 – December 31, 2016

<table>
<thead>
<tr>
<th>Total Time Units</th>
<th>Total Number of Visits</th>
<th>Your Average</th>
<th>Your State’s Average</th>
<th>Comparison with Your State’s Average</th>
<th>National Average</th>
<th>Comparison with the National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>212.3</td>
<td>83</td>
<td>2.56</td>
<td>2.50</td>
<td>Higher</td>
<td>2.27</td>
<td>Significantly Higher</td>
</tr>
</tbody>
</table>

A t-test was used in this analysis, alpha = 0.05

\[
\frac{212.3}{83} \approx 2.56
\]
Percentage of Visits Billed without an Allowed Colonoscopy Claim

Calculated as follows:

\[
\left( \frac{\text{Number of Visits without Colonoscopy}}{\text{Total Number of Visits}} \right) \times 100
\]
Table 4: Percentage of Visits without an Allowed Colonoscopy Claim  
January 1, 2016 – December 31, 2016

<table>
<thead>
<tr>
<th>Visits without Colonoscopy</th>
<th>Total Number of Visits</th>
<th>Your Percent</th>
<th>Your State’s Percent</th>
<th>Comparison with Your State’s Percent</th>
<th>National Percent</th>
<th>Comparison with the National Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>83</td>
<td>1%</td>
<td>7%</td>
<td>Does Not Exceed</td>
<td>4%</td>
<td>Does Not Exceed</td>
</tr>
</tbody>
</table>

A chi-square test was used in this analysis, alpha = 0.05

\[
\left( \frac{1}{83} \right) \times 100 = 1\%
\]
Percentage of Visits Appended with Modifier AA

Calculated as follows:

\[
\left( \frac{\text{Number of Visits with Modifier AA}}{\text{Total Number of Visits}} \right) \times 100
\]
Table 5: Percentage of Visits Appended with Modifier AA
January 1, 2016 – December 31, 2016

<table>
<thead>
<tr>
<th>Visits with Modifier AA</th>
<th>Total Number of Visits</th>
<th>Your Percent</th>
<th>Your State’s Percent</th>
<th>Comparison with Your State’s Percent</th>
<th>National Percent</th>
<th>Comparison with the National Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>76</td>
<td>83</td>
<td>92%</td>
<td>27%</td>
<td>Significantly Higher</td>
<td>47%</td>
<td>Significantly Higher</td>
</tr>
</tbody>
</table>

A chi-square test was used in this analysis, alpha = 0.05.

\[
\left(\frac{76}{83}\right) \times 100 = 92\%
\]
Who Received a CBR?

- Significantly Higher Than Peers
- $5,000 Allowed Charges
- 19 Beneficiaries
References & Resources
Comparative Billing Reports (CBRs) are educational tools administered by the Centers for Medicare & Medicaid Services (CMS). They are developed and disseminated under contract by eGlobalTech, a woman-owned Federal services firm based in Arlington, VA.

The CBRs are disseminated to the provider community to provide insight into billing trends across regions and policy groups. A/R MACs have been producing and disseminating limited numbers of CBRs to targeted providers for many years. CMS has now formalized and expanded the program to a national level. The program also includes a CBR Support Help Desk that providers can contact to ask questions regarding the CBRs. Following the release of each CBR, eGT will hold an educational teleconference or webinar to educate providers on the substance of the CBR and to provide an opportunity for providers to ask questions.

**CBR Website**

http://www.cbrinfo.net

- About Us
- CBR Releases
- Education
- Recommended Links
- FAQs
- CBR Support
- Contact Us
http://www.cbrinfo.net/cbr201705

- Webinar
- Sample CBR
- Statistical Debriefing
- Recommended Links
- FAQs
Provider Self-audit

- Providers and suppliers have an obligation to ensure claims are submitted correctly to Medicare
- Self-audits allow providers and suppliers to identify coverage and coding errors
- Refer to the following CBR sections for assistance
  - Documentation and Billing
  - References
CBR Support Help Desk

Monday–Friday: 9:00a.m. to 5:00p.m. ET

- Toll Free 1–800–771–4430
- Email: cbrsupport@eglobaltech.com
Contacting MACs

Providers should contact the Medicare Administrative Contractor (MAC) for assistance with:

- Claim Information
- Documentation Requirements
- Billing and Coding
Provider Enrollment, Chain, and Ownership System (PECOS)

- Source for mailing address used for the CBR
- Correct your mailing information at

https://pecos.cms.hhs.gov/pecos/login.do
Questions & Answers
We make every effort to address all questions submitted during our webinars. However, we cannot provide responses related to coding issues or to specific claims/scenarios. Since your Medicare Administrative Contractor (MAC) makes the determination to pay or deny a claim based on the CPT® or HCPCS codes, medical documentation and description of the circumstances, and we do not have access to this documentation, we cannot respond to these types of questions. Please contact your MAC with questions that we do not address or if you identify any claims discrepancies while reviewing your CBR. The contact information for your MAC is located at http://go.cms.gov/IMap.