Anesthesiology Billing
How to Ensure Proper Reimbursement and Avoid a RAC Audit
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Introduction: The Aggressive RAC Audit

Anesthesiology practices are particularly vulnerable to Medicare audits because of the unique complexities of the billing process when it comes to time calculation, coding, and other areas. The federal government’s Recovery Audit Contractors (RAC) program fully understands this vulnerability and is making the most of it, with aggressive audits to recoup any money that the government deems was issued inappropriately.

The federal government has instituted the RAC program by contracting with non-governmental firms to provide audits and setting up an incentive plan whereby the auditors only get paid when they identify billing mistakes within a practice and recoup Medicare overpayments. This sets the stage for a very aggressive auditing approach, with the federal False Claims Act setting penalties as high as $11,000 per claim, plus three times the claim amount, plus legal fees.

Because the Tax Relief and Health Care Act of 2006 made the RAC program permanent, these aggressive audits will only continue over the coming years. Indeed, the RAC program will be required in all 50 states by 2011.

This paper recaps some of the most vulnerable areas in anesthesiology billing. Its purpose is to provide a reference guide and reminder to ensure all bases are covered when it comes to proper billing and appropriate reimbursement for an anesthesiology practice.

Common Audit Problems

A brief summary of the billing areas that are commonly cited as problems is included below. These billing areas are frequent stumbling blocks to ensuring an anesthesiology practice is reimbursed fully and appropriately for its work.

Time
- Definition of start and stop time
- Rounding of time
- Lack of monitoring to support the time submitted on the claim
- Consistently billing five minutes prior to “in room” time and 10 minutes after “out of room” time
- Routinely including ancillary services in anesthesia time

Coding
- Incorrect codes entered for procedures
- Missing base units due to lack of proper documentation of the procedure
- Upcoding or using a higher code in order to bill more units

Medical direction
- Medical direction documentation areas
- Pre-anesthesia assessments not done
- Medically directing more rooms than allowed
- Medical director not immediately available — relief, breaks, leaving the area
- Frequent monitoring or not documenting the monitoring
- Pre-signing records
- Performing a case while medically directing another
Ancillary services
- Procedures used primarily for post-op pain
- Failure to document that the service was requested by the surgeon
- Inadvertent dual management with surgeon
- Billing for the ancillary services during anesthesia time

OB anesthesia
- Inconsistency in use of billing methods, e.g., total time with cap, actual face time, flat fee, etc.
- Inadequate documenting of face-to-face time
- Billing under the wrong provider
- Billing all OB services as emergencies

Medical necessity
- Must meet the standards of good medical practice in the local area
- Are not mainly for the convenience of the patient or provider
- MAC (GI and Cath Lab procedures)
- Post-op pain
- Invasive lines

Incidental services
- Catheter placement, etc., or billing if an additional catheter is placed
- Coding an additional service if more than one monitoring device is used with the same “stick.” Examples include arterial lines, CVPs, Swan-Ganz catheters, blocks for pain management, TEE (Transesophageal Echocardiography)

Incidental services with time
- Because incidental services are billed as a flat-fee with CPT code, there can be no time associated with them in the billing calculation

Unbundling
- Breaking services out and billing as separate services when they should all be included in one CPT code

MAC vs. General vs. TIVA Anesthesia
- There continues to be confusion over monitored Anesthesia Care vs. General Anesthesia vs. Total IV Anesthesia
Anesthesiology Billing: How to Ensure Proper Reimbursement and Avoid a RAC Audit

How to Prevent an Audit: Key Points to Review

Much of the information provided here is common knowledge and will serve as a reminder, but some of the information is new and critical to proper coding and billing.

Generally, these guidelines apply to all carriers (governmental as well as commercial).

Anesthesia is a professional service and is billed using the CMS-1500 claim form. The anesthesia claim is calculated as follows:

- Base Units (value assigned by the American Society of Anesthesia to each procedure/surgery)
  
  plus

- Time Units (actual time of surgery as calculated by start and stop time)
  
  plus

- Special Units (modifying units such as age of patient, medical condition, etc.)

If the surgery is a non-covered service, the anesthesia is also non-covered. In addition, coverage of certain procedures is limited by the diagnosis. If the diagnosis listed on the claim is not a covered service based on Medicare guidelines, the procedure will be denied. It is important to make sure that the diagnosis is coded to the highest level of specificity. In addition, it is important that the diagnosis match the surgeon's operative notes.

Accurate Coding and Documentation are Vital

Good communication between the anesthesiologist and the billing staff is the key to proper anesthesia coding and billing. It all comes down to accurate and thorough documentation. Inaccurate or inadequately documented anesthesia records lead to inaccurate (false) claims. Providing complete and accurate information to the billing staff promotes compliance and accelerates the billing and collection process.

Inconsistencies in the anesthesia record are potential false claims. For example:

- Documentation showing the same physician in two places at one time
- CRNA with overlapping case times
- Services marked on a billing slip but no accompanying documentation in the anesthesia record

Here are other examples of critical documentation that can affect coding:

- **Documentation on spinal procedures.**
  You must specify if the procedure involved instrumentation. You must state any of the following to indicate instrumentation:
  - Cages
  - Hooks
  - Pedicle Fixation
  - Plating
  - Rods
  - Screws
  - Wires
  Any of these statements will add three to five base units to the service depending on the spinal region. It is estimated that 90% of spinal surgeries use instrumentation.
• **Documentation on approach:**
  › It is important to document the approach taken. For example:
    • Upper vs. lower abdomen
    • Prostate procedures – perineal vs. transrectal

• **Documentation on position:**
  › Position other than supine (i.e. unusual positions) can give you up to five additional base units, depending on which unusual position was used. For example:
    › Anesthesia for pain procedures – prone vs. other – possible two additional units
    › Cervical spine procedures – Sitting vs. other – possible three additional units

• **Documentation on technique:**
  › Some techniques will allow you to add two to three additional units. For example:
    • Two-lung vs. one-lung ventilation – possible two to three additional base units
    • Diagnostic vs. surgical arthroscopies – possible one additional unit (i.e. Knee arthroscopy vs. knee arthroscopy with meniscus repair)

• **Documentation of site:**
  › Proper documentation of site may allow you to add one to two additional units. For example:
    • Upper leg vs. lower leg, upper two-thirds femur vs. lower one-third femur – possible one additional unit
    • Cervical, thoracic, or lumbar – possible one additional unit
    • Posterior vs. anterior trunk – possible two additional units

**Base Units**

Each anesthesia CPT code has an established value assigned based on the complexity of the surgery. The ASA assigns and updates base units on an annual basis. Pay particular attention to the items that Medicare considers integral parts of the anesthesia service and are included in the procedure. These services are paid as part of the “base units” and should not be billed separately.

• Transporting, positioning, prepping, draping of the patient
• Placement of external devices necessary for cardiac monitoring, oximetry, temperature, EEG, etc.
• Placement of peripheral intravenous lines necessary for fluid and medication administration
• Placement of an airway
• Placement of naso-gastric or oro-gastric tube
• Intra-operative interpretation of monitored functions
• Interpretation of lab determinations
• Nerve stimulation for determination of level of paralysis or localization of nerve
• Insertion of urinary bladder catheter
• Blood sampling
Time Units
Errors and inconsistencies in time reporting continue to be a problem area. For example, if a surgical procedure starts at 9:05 a.m. and finishes at 10:05 a.m., an anesthesiologist might add five minutes to his or her time to include pre-op preparation, and so the billing company bills for one hour and five minutes. An auditor finds, however, that the nurse’s notes say the procedure was only an hour and will claim that the anesthesiologist “padded” the time.

It is helpful to review the Medicare definition of anesthesia time here, because being lax in the definition of start and stop time is one of the most common billing errors.

“Anesthesia time is defined as the period during which an anesthesia practitioner (Physician, CRNA, AA, etc) is present with the patient. It 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.” (From Medicare Claims Processing Manual, Chapter 12 at page 118.)

Most insurance carriers allow one time unit for each 15-minute interval, or fraction thereof, starting from the time the physician begins to prepare the patient for induction and ending when the patient may safely be placed under post-operative supervision and the anesthesiologist is no longer in personal attendance.

Other points to consider:

- Actual time units will be paid
- Do not round time up or down. Use actual time and do not calculate aggressively
- Do not add units
  - In the past, some anesthesiologists would add a few minutes to the beginning and/or end of a case. This creates a “false claim” and will be monitored closely in a government audit and may remain a high concern for commercial carriers as well.
- Anesthesia time must be supported by documentation of monitoring in the anesthesia record
- For billing purposes, the billing company needs a copy of the anesthesia record

Anesthesia start & stop time
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 requires the continuous presence of the anesthesiologist or CRNA when medically directing.

- Anesthesia start and stop time must be reported in actual minutes
- It is important to document transfer time to recovery room personnel
- Time stops if “qualified individual” is not with the patient. A qualified individual is one who can be medically directed by an anesthesiologist:
  - AA or CRNA
  - Residents and Interns
- A holding area nurse, circulating nurse, or medical student is NOT a “qualified individual”

Pre-op and post-op time
- The pre-op exam time is included as part of the base units and should not be included in the anesthesia time
- Pre-op exam must be done within 48 hours prior to the surgery
- Pre-op evaluation should include:
  - Review of history
  - Interview/exam
  - ASA risk classification
  - Potential anesthesia problems
  - Additional anesthesia evaluation (i.e. stress tests, specialist consult, etc.)
  - Anesthesia plan
• Post-op evaluation should include (performed within 48 hours after surgery):
  › Respiratory function
  › Cardiovascular function
  › Mental status
  › Temperature
  › Pain
  › Nausea/vomiting
  › Post-op hydration

• For outpatients, post-op evaluation must be completed prior to discharge

• Anesthesia ends when the anesthesiologist is no longer in personal attendance or when the patient may be safely placed under postoperative supervision

**Discontinuous time**

When anesthesia time is interrupted, follow the Medicare Carriers Manual rules closely.

“For services on or after Jan 1, 2000, the anesthesia practitioner can add blocks of time around an interruption in anesthesia time, as long as the anesthesia practitioner is furnishing continuous anesthesia care within the time periods around the interruption.”

Important points to remember are:

• The anesthesia record should clearly show when anesthesia time starts and stops
• The total time billed should match the time blocks documented on the anesthesia record
• Do not use discontinuous time for relief issues, such as restroom breaks, when medical direction is broken (see section on Medical Direction in this paper) or when an anesthesiologist must leave in the middle of a case

**Special Units**

Special Units, or modifying units, are additional units that may be added to the total billable units calculation if certain conditions are met. Examples:

- 99100 – Patient is extreme age, under one year or over 70 years – additional one unit
- 99116 – Anesthesia complicated by total body hypothermia – additional five units
- 99135 – Anesthesia complicated by controlled hypotension – additional five units
- 99140 – Anesthesia complicated by emergency condition – additional two units (An emergency, defined by ASA, is when delay in treatment of the patient would lead to a significant increase in the threat to life or body part.)

Other Special Units include physical status modifying units:

- P1 – A normal healthy patient – zero additional units
- P2 – Patient with mild systemic disease – zero additional units
- P3 – Patient with severe systemic disease – one additional unit
- P4 – Patient with severe systemic disease which is a constant threat to life – two additional units
- P5 – A moribund patient who is not expected to survive the operation – three additional units
- P6 – A declared brain-dead patient whose organs are being harvested – zero additional units

**Invasive Monitoring Devices**

Placement of arterial, central venous and pulmonary artery catheters and TEE are not included in the base units. However, Medicare does include routine monitoring on TEE on heart cases in the base units.

- For arterial and central lines
  › No additional time billed, if placed prior to induction
  › Placement as well as monitoring should be documented
  › Documentation in anesthesia record should include; site, needle size and who placed the line
  › Should be billed under the performing provider
Consultations

Consultations for surgical patients are considered part of the anesthesia service and are not separately billable. However, consultations for pain management patients are allowable services.

- Requirements for billing consultations are:
  - The referring physician must request an opinion or advice regarding evaluation and/or management of a specific problem
  - The referring physician’s request and the need for consultation must be documented in the patient's medical record
  - The consultant must prepare a written report of his/her findings, which is provided to the referring physician

Billing for Personally Performed Services

Under Medicare regulations, an anesthesia procedure is considered “personally performed” by the anesthesiologist if the physician is continuously involved in a single case. When billing for personally performed physician services (AA modifier), the physician may not leave the operating room to perform other medical procedures.

The anesthesiologist must remain physically present in the operating room during the entire procedure. If the anesthesiologist is not continuously involved with the case, then it is not considered a personally performed service and should be reported using the medical direction modifiers.

Billing for Medical Direction

The specialty of anesthesia allows the physician anesthesiologist to medically direct non-physician anesthesia providers and to bill for services that are not “personally performed.” The distinctions between “medical direction” and “medical supervision” for billing purposes in these instances will be highlighted in the sections that follow.

Medical direction is a covered service only if the anesthesiologist:

- Performs the pre-anesthesia examination and evaluation
- Prescribes the anesthesia plan
- Personally participates in the most demanding procedures of the anesthesia plan, including induction and emergence
- Ensures that any procedures in the anesthesia plan that he/she does not perform are performed by a qualified individual
- Monitors the course of anesthesia administration at intervals
- Remains physically present and available for immediate diagnosis and treatment of emergencies
- Provides indicated post-anesthesia care

Note: For medical direction, the physician must personally document in the medical record that he/she met all seven requirements listed above. Two separate claims must be filed for medically directed anesthesia procedures – one for the anesthesiologist and one for the CRNA.

A medical directing anesthesiologist may perform other duties concurrently to include: (i.e., six permissible activities while medically directing):

- Addressing an emergency of short duration in the immediate area
- Administering an epidural or caudal anesthetic to a patient in labor
- Performing periodic monitoring of an obstetrical patient, rather than continuous monitoring
- Checking on or discharging patients in the post-anesthesia care unit (PACU)
- Coordinating scheduling matters
- Receiving patients entering suite for the next surgery
**Medical Supervision**

The words “medical supervision” and “medical direction” are often used interchangeably, but for Medicare and many other insurance carriers for reimbursement purposes, the two terms mean different things. Understanding the distinctions is vitally important to accurate billing.

If the anesthesiologist is medically directing more than four CRNAs, the service must be billed as medically supervised rather than medically directed. Keeping track and properly documenting time spent in medically supervised procedures is one of the biggest billing problems today and frequently raises a “red flag” with auditors. Here are some key tenets of accurately billing medically supervised time:

- Payment to the anesthesiologist will be based on three base units per procedure when the anesthesiologist is involved in furnishing more than four procedures concurrently or is performing other services while directing the concurrent procedure.
- An additional time unit can be recognized if the physician can document he/she was present at induction.

**Concurrent Procedures – How to Determine**

Concurrency is defined as the maximum number of procedures the anesthesiologist is medically directing or supervising and whether these other procedures overlap each other, irrespective of the patient’s insurance carrier.

For billing purposes, count all the cases in which the provider participated.

- This includes the number of cases that are occurring at an individual moment in time.
- This applies to all providers who are involved with the case.
- Not just the provider whose name the case is being billed under.
- An overlap in time of even one minute constitutes a concurrent case.

For example: Procedures A through E are medically directed procedures involving CRNAs. The starting and ending times for each procedure represent the periods during which anesthesia time is counted.

- Procedure A: Begins at 8:00 a.m. and ends at 8:21 a.m.
- Procedure B: Begins at 8:11 a.m. and ends at 8:46 a.m.
- Procedure C: Begins at 8:32 a.m. and ends at 9:30 a.m.
- Procedure D: Begins at 9:00 a.m. and ends at 11:59 a.m.
- Procedure E: Begins at 9:10 a.m. and ends at 9:56 a.m.

**Monitored Anesthesia Care (MAC)**

Here is another area requiring special attention when billing services. Indications for monitored anesthesia care include the nature of the procedure, the patient’s clinical condition, and/or the potential need to convert to a general or regional anesthetic. MAC services are only payable if medically reasonable and necessary and the intra-operative monitoring of the patient’s vital physiological signs are documented in the chart in anticipation of a general anesthetic.

During MAC, the anesthesiologist must provide or medically direct a number of specific services, including but not limited to:

- Diagnosis and treatment of clinical problems that occur during the procedure.
- Support of vital functions.
- Administration of sedatives, analgesics, hypnotics, anesthetic agents or other medications as necessary for patient safety.
- Psychological support and physical comfort to patient.
- Provision of other medical services as needed to complete the procedure safely.

Monitored anesthesia care may include varying levels of sedation and analgesia as necessary. The provider of MAC must be prepared and qualified to convert to general anesthesia when necessary. If the patient loses consciousness and the ability to respond purposefully, the anesthesia care becomes a general anesthetic, irrespective of whether airway instrumentation is required.
Anesthesia Modifiers
Modifiers are two-digit indicators used to modify payment of a procedure code, assist in determining appropriate coverage, or identify the detail on the claim. Every anesthesia procedure billed to all carriers must include one of the following anesthesia modifiers.

**Anesthesiologist:**

<table>
<thead>
<tr>
<th>MODIFIER</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>-AA</td>
<td>Anesthesia services personally performed by the anesthesiologist</td>
</tr>
<tr>
<td>-QY</td>
<td>Medical direction of one CRNA by an anesthesiologist</td>
</tr>
<tr>
<td>-OK</td>
<td>Medical direction of two, three or four concurrent anesthesia procedures</td>
</tr>
<tr>
<td>-AD</td>
<td>Supervision, more than four procedures</td>
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</table>

**CRNA:**

<table>
<thead>
<tr>
<th>MODIFIER</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>-QX</td>
<td>Anesthesia, CRNA medically directed</td>
</tr>
<tr>
<td>-QZ</td>
<td>Anesthesia, CRNA not medically directed</td>
</tr>
</tbody>
</table>

**MAC:**

<table>
<thead>
<tr>
<th>MODIFIER</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>-QS</td>
<td>Monitored Anesthesia Care (MAC) services</td>
</tr>
<tr>
<td>-GB</td>
<td>Monitored Anesthesia Care (MAC) for deep complex, complicated or markedly invasive surgical procedure</td>
</tr>
<tr>
<td>-GB</td>
<td>Monitored Anesthesia Care (MAC) for patient who has history of severe cardio-pulmonary condition</td>
</tr>
</tbody>
</table>

**Physical Status:**

<table>
<thead>
<tr>
<th>MODIFIER</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>-P1</td>
<td>A normal healthy patient</td>
</tr>
<tr>
<td>-P2</td>
<td>A patient with mild systemic disease</td>
</tr>
<tr>
<td>-P3</td>
<td>A patient with severe systemic disease</td>
</tr>
<tr>
<td>-P4</td>
<td>A patient with severe systemic disease that is a constant threat to life</td>
</tr>
<tr>
<td>-P5</td>
<td>A moribund patient who is not expected to survive without the operation</td>
</tr>
<tr>
<td>-P6</td>
<td>A declared brain-dead patient whose organs are being removed for donor purposes</td>
</tr>
</tbody>
</table>

**Qualifying Circumstances:**

<table>
<thead>
<tr>
<th>CPT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>99100</td>
<td>Anesthesia for extreme age, under 1 year and over 70 years</td>
</tr>
<tr>
<td>99116</td>
<td>Anesthesia complicated by utilization of total body hypothermia</td>
</tr>
<tr>
<td>99135</td>
<td>Anesthesia complicated by utilization of controlled hypotension</td>
</tr>
<tr>
<td>99140</td>
<td>Anesthesia complicated by emergency conditions (An emergency is defined when delay in treatment of the patient would lead to a significant increase in the threat to life or body part.)</td>
</tr>
</tbody>
</table>

Incidental Services

Certain procedures are billed as a flat-fee service with a specific CPT code. There is no time associated with these charges.

- Arterial Lines
- CVPs
- Swan-Ganz catheters
- Blocks for pain management
- TEE

Post-Op Pain

The key to proper billing of post-op pain procedures is good documentation. Management of pain is usually at the request of the surgeon and should be documented in the patient’s chart. There is no time associated with these charges.

Proper documentation includes:

- Location and nature of injection or catheter
- Purpose and intent of injection or catheter
- Epidurals: Clearly document that these were inserted for post-op pain.
- The following are the most common post-op pain injections by site:
  - 62318 – Cervical, thoracic (continuous)
  - 62319 – Lumbar, sacral (continuous)
  - 62310 – Single injection, cervical or thoracic
  - 62311 – Single injection, lumbar or caudal
  - 64415 – Interscalene block
  - 01996 – Follow-up days (used for monitoring PCA pumps)
Patient Controlled Analgesia (PCA)
This can be billed as a separate service if properly documented. It should never be billed to government payors due to CCI bundling edits. (Medicare considers PCA part of the base procedure.)

PCA should not be billed as a result of “standing orders” in the recovery room. It must be requested by the surgeon and documented in the chart.

PQRI for Anesthesia
Three main areas for PQRI for anesthesia billing are:

- Pre-Op Antibiotic – Timing of prophylactic antibiotic
  - 4047F – Documentation of an order in the chart for prophylactic antibiotics to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision
  - 4048F-1P – Measure was met
  - 4048F-8P – Antibiotic not given within time frame prior to surgical incision

- CVP – Central Venous Catheter under Maximal Sterile Barrier Technique tracked by CPT code 36555/36556.
  - 6030F – Measure met
  - 6030F-1P – Measure not met due to medical reason
  - 6030F-8P – Measure not met due to other reasons

- Ventilator Associated Pneumonia - 99291 signals the measure.
  - 4168F – Patient receiving care in ICU and receiving mechanical ventilation 24 hours or less
  - 4169F – Patient not eligible for measure due to not receiving mechanical ventilator
  - 4167F – Measure met, head of bed elevation 30 to 45 degrees
  - 4167F-1P – Measure not met due to medical reason
  - 4167F-8P – Measure not met due to other reason

Miscellaneous Special Coding Issues
Services that can be distinct and separate if done at a separate encounter not related to the anesthesia service may be billed using Modifier 59.

- Cancelled surgery prior to induction can be billed with the appropriate E&M code. Reason for cancelled surgery should be properly documented in the patient’s chart.

- Post-operative pain service can be reported and billed separately if two conditions are met:
  - It must be done outside of anesthesia time (start and stop time of surgery)
  - Surgeon must document in the medical record the reason the care is being referred to the anesthesia provider

Medical Necessity
Medical necessity is defined as those services that are reasonable and necessary for the diagnosis or treatment of an illness or injury, or to improve the functioning of a malformed body member and are not excluded under a patient’s insurance plan.

The necessity for the procedure must be carefully documented and must meet the standards of good medical practice in the local area. You must demonstrate that the services are not mainly for the convenience of the patient or provider. Pay particular attention to carefully document medical necessity for:

- MAC (GI and Cath Lab procedures)
- Post-op pain
- Invasive lines
Conclusion:
Getting It Right

There are two types of RAC audits today: automated, where no medical record is requested, and complex, where the medical records will be requested. The RAC auditors cannot review claims paid prior to October 1, 2007. However, the auditors can look back three years from the date the claim was paid. What’s more, the RAC audit firms are using a pre-existing database of medical specialty claims to profile physician billing behavior and to identify providers submitting false claims.

The point is that RAC audits are a reality in medical practice today, and wise practitioners keep this reality top of mind. It is important to have a billing partner like Orion HealthCorp that is working to ensure claim accuracy and avoidance of audit issues for our clients.

A Team Effort

The billing partner cannot be the only one responsible for claim accuracy. There must be good communication between the anesthesiologist and the billing staff. It begins with good documentation at every key step of a surgical procedure, including the checking of vital signs, status of the patient, and risk factors.

Notes must be legible and every tick mark clear, or it could result in extra time after the fact as the billing company attempts to clarify the notations. In some cases where there is a question regarding actual time spent or other item, the billing will have to be “downcoded” in order to avoid an inappropriate billing citation in an audit.

With clear documentation from the outset of an operation, your practice can collect the amount that is legally and rightfully due to you for the services that you provide.

For a review of your practice’s anesthesia coding procedures, please call Orion HealthCorp at 888.440.4772 or email us at info@orionhealthcorp.com.

About Orion HealthCorp

Orion HealthCorp, Inc. is a trusted partner to physicians who require the specialized medical billing and practice management processes and technology necessary to successfully maximize the recovery of earned revenue and to manage stringent industry compliance mandates and insurance intermediaries. The company supports thousands of office-based physicians and hospital specialists in pathology, radiology, and anesthesiology; and delivers an intense focus on personal relationships and company accountability. Innovative tools, technologies, and operational processes enable the Orion team to capture missing revenues that other companies overlook and help clients mitigate the risks associated with choosing a billing partner or implementing a new billing process. Headquartered in Roswell, Ga., with offices in Alabama, California, Colorado, Illinois, Ohio and Texas, Orion HealthCorp is among the top medical billing and practice management companies in the United States. For more information, please visit www.orionhealthcorp.com.