

## FEATURE STORY

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## breathing easy auditing your anesthesia practice revenue cycle

For hospitals that own or subsidize an anesthesia practice, ongoing auditing is essential to maximizing revenue and minimizing risk.

### AT A GLANCE

The following steps should be part of any anesthesia revenue cycle auditing program:

- > Scrutinize documentation.
- > Verify compliance.
- > Check coding.
- > Examine billing and collections.
- > Solve identified problems.

As the national shortage of anesthesiologists grows more severe, hospitals across the country are taking steps to protect themselves. Many hospitals now employ an anesthesia group, and an increasing number subsidize a group in exchange for full anesthesia coverage in the operating room (OR).

These strategies are important for maintaining a hospital's revenue base. However, they also introduce a hidden challenge: the unique payment rules that govern anesthesia services. These rules make it harder for anesthesia groups to maintain top financial performance—and easier for them to get into regulatory trouble. For hospitals that employ or subsidize an anesthesia group, the risk is that these problems will make anesthesia coverage very expensive indeed.

### Extra Steps: Necessary, but Worth It

Unlike most other physicians who are paid on a fee-for-service basis, anesthesiologists are paid according to a *base-plus-time-plus-modifiers* methodology that takes into account a wide variety of factors, including stringent regulations governing concurrency. One practical result is that anesthesia payment is highly dependent on careful documentation, which makes it vulnerable to human error. In addition, unique payment information requirements make anesthesia coding a special challenge. The difficulties also extend to the back end—billing software designed for other specialties fails to meet many needs of the anesthesia practice. The overall result for anesthesia practices is a greater danger of lost revenue and greater exposure to compliance risk.

To maximize financial performance and control risk, a hospital with a financial stake in an anesthesia practice should take extra steps to ensure the integrity of the practice's revenue cycle. The key is creating an ongoing audit program to make sure documentation is complete and accurate, coding is detailed and correct, billing and collections are efficient and effective, and all processes comply with payer regulations and contracts.

## Step 1: Scrutinize Documentation

The foundation of an anesthesia audit program is a close examination of the practice's underlying documentation. What makes this a challenge is the fact that anesthesiologists provide services in several different settings besides the OR, including the surgical intensive care unit, cath labs, magnetic resonance imaging (MRI) suites, gastrointestinal suites, electroconvulsive therapy rooms, pain clinics, and the hospital floor. There are often no processes in place to make sure out-of-OR services are properly documented. The same is true of add-on cases, which often do not end up on an OR schedule. Tracking anesthesia services means hunting down documentation that is potentially scattered throughout the organization.

As a starting point, auditors should choose two successive calendar days and obtain complete records for each. Because the goal is to track the services provided on these days throughout the revenue cycle, pick dates that are 90 to 120 days out. For each date, acquire copies of the following documents and records:

- > OR schedule and add-ons
- > Obstetrics log
- > Acute pain schedules
- > HCFA 1500
- > Anesthesia record
- > Concurrency report
- > Billing tickets (if applicable)
- > Screen prints of anesthesia charges, including providers, start and stop times, base and time units, Current Procedural Terminology/American Society of Anesthesiologists (CPT/ASA) codes, and all modifiers

The first priority is to make sure all documented cases and services are reflected in a corresponding charge. Tracking cases in this way could uncover a large number of documented services that never made it to billing. A second priority is to ensure documentation includes all factors that can lead to higher coding. If anesthesia records fail to document emergency status, for example, the provider could easily be missing out on additional revenue.

Pay careful attention to intra-operative procedures that can be billed separately, such as arterial lines, central venous pressure catheters, Swan-Ganz catheters, and transesophageal echocardiographs. Make sure claims for these procedures are supported by documentation of medical necessity. For charge capture purposes, it is important that intra-operative procedures be clearly documented on the anesthesia record. Absence of claims for these procedures could indicate underbilling.

Also, take a close look at out-of-OR procedures. Although cases recorded in the OR schedule or the anesthesia record usually feed easily into the revenue cycle information stream, the same is not true of services provided outside of surgery. For example, information from post-operative pain rounds will go into the patient chart, but may not make it to the billing department. Other examples are emergency department services, emergency obstetrics, and services provided in cardiac cath and MRI labs. Examining a wide range of hospital logs and records will help you determine whether all billable services—both in and out of the OR—are being captured.

## Step 2: Verify Compliance

Anesthesiologists are the only specialists who must meet all seven steps of medical direction

### SEVEN CONDITIONS FOR MEDICAL DIRECTION

The following is quoted from the *Medicare Carrier Manual*, Section 15018, "Payment Conditions for Anesthesiology Services" (subsection C):

Medical direction occurs if the physician medically directs qualified individuals in two, three, or four concurrent cases and the physician performs the activities described as follows:

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

when directing more than one case (see sidebar on page 75). Failure to meet even one of them will invalidate a claim for medical direction payment, reducing it to medical supervision (and significantly lowering payment). Confusion here can easily lead to overbilling and makes the process vulnerable to fraud. In fact, more penalties and fines have been assessed against anesthesia practices for violation of Medicare medical direction guidelines than any other aspect of anesthesia billing.

## For hospitals that own an anesthesia practice, the payoff can include better revenue performance and greater protection from legal risk.

Coding modifiers that detail level of concurrency are, in effect, pricing modifiers, because they inform Medicare (and other payers) how to price a service. The compliance risk is billing for medical direction without having complete documentation to back it up. If the Centers for Medicare and Medicaid Services audits an anesthesia practice and discovers inadequate documentation of medical direction, the practice will be required to pay back the difference between payments and what the documentation actually supports.

When auditing for concurrency, check for accurate documentation of start and stop times and examine concurrency reports for any case time overlaps. In addition, make sure all providers are signing in and out of time logs on anesthesia records by themselves and are not rounding times. Documentation to support concurrency must accurately track type of provider (physician, resident, certified registered nurse anesthetist [CRNA], student CRNA) as well as relief providers for lengthy cases. Make sure services are billed under the provider with the most time on a case and that billing software is calculating concurrency properly.

### Step 3: Check Coding

After auditing documentation for completeness and accuracy, focus attention on coding. For

some practices, poor coding can lead to hundreds of thousands of dollars in legitimate charges falling out of the revenue cycle. There is also legal risk; errors that result from incorrect coding are the liability of the provider, not the coder or billing company.

When auditing coding performance, pay attention to a handful of key issues. First, make sure that services are coded using the highest base unit

that is appropriate for the anesthesia encounter. For example, a diagnostic cystourethroscopy could represent three base units, while a cystourethroscopy with bladder tumor resection could code at five

base units. Second, make sure codes include all appropriate modifiers, such as modifiers for patient age, physical status, emergency services, and complications. Depending on the payer and contract, these factors can lead to higher payment. Third, determine whether CPT codes are crossing to the correct ASA codes in software maintenance files. There are more than 6,000 CPT codes and only 350 ASA codes, and faulty crosswalks can result in chronic billing mistakes.

### Step 4: Examine Billing and Collections

Losses from poor billing and collections performance can represent a significant portion of an anesthesia group's net revenue. To get a close look at back-end performance, auditors should examine claims in one late aging category and investigate the reasons that are holding up payment. A good place to focus is the 90-to-120-day aging bucket. Generate a report on this category and go through the claims one by one, tracing each one backward through the revenue cycle until the problem that is keeping it from being reimbursed has been identified.

Possible findings can include such issues as incomplete or incorrect claim information. For example, a simple problem like a missing code could result in a significant delay in payment. Payment problems can also stem from the failure

to follow payer processes. Another discovery could be a high level of variances or improper denials that are the fault of the payer. Ultimately, the audit could reveal problems with documentation, coding, and compliance that are gumming up the payment process.

What if the practice uses an outside billing company? Because claims are being handled by a professional billing firm, does that mean auditors do not need to examine billing and collection performance? On the contrary—the performance of anesthesia billing providers should be monitored, and good billing partners will welcome the attention.

Although there are many effective billing companies in the industry, some do not take a persistent approach to collections; they collect the unproblematic dollars, but let the difficult claims drop. For a typical multiphysician anesthesia practice, the lost revenue can add up to millions of dollars. Auditing the company's performance serves two purposes. First, it can uncover process frictions and trouble spots that are leading to lost reimbursement. Second, it can open a dialogue with the billing company, refocusing the relationship on achieving higher collections performance.

### Step 5: Solve Identified Problems

The value of an anesthesia audit is that it provides detailed information on problems, weak spots, and potential risk areas within the anesthesia practice's revenue cycle. To make an audit program truly effective, the next step is to close the loop on the process by digging in and solving identified problems.

In the case of a hospital-owned anesthesia practice, hospital financial leaders and practice administrators can work together on performance improvement initiatives. Where the link is a group subsidy, improvement steps may need to be discussed in the context of contract negotiations.

In either case, typical initiatives include:

- > Working with physicians (as a group or individually) on documentation practices and compliance issues

- > Creating processes for ensuring all charges feed into the billing stream
- > Educating coders (as a group or individually) on recurring coding problems
- > Working within the billing department to solve problems that are leading to high edits/rejections and poor cash flow
- > Identifying issues, such as payment for qualifying circumstances and physical status, that can be addressed through managed care contracting

### An Investment that Pays Off

An audit program requires an investment of resources. Because coding regulations are always changing and compliance risk is constant, front-end audits should be conducted quarterly. Each quarterly audit could require two to three days of work by an individual knowledgeable in anesthesia documentation, coding, and regulation. Back-end audits should take place annually. This could involve several days of work by a small team of revenue cycle professionals.

Healthcare organizations that devote resources to an anesthesia audit program find the return is substantial. For hospitals that own an anesthesia practice, the payoff can include better revenue performance and greater protection from legal risk. For hospitals that subsidize an anesthesia group, helping to maximize practice revenue can be an important part of controlling the cost of support. ●

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