Commonwealth Anesthesia Associates
MEDICAL BILLING COMPLIANCE PLAN

Revised July 1, 2014

1. INTRODUCTION

Commonwealth Anesthesia Associates (CAA) is committed to providing excellent quality anesthesia services with billing activities that are compliant with applicable law. We recognize the need to ensure that our physicians, CRNAs, and staff are well informed about Federal and State regulations applicable to billing, that we comply with these rules, and that performance is regularly audited with follow-up procedures that improve detected weaknesses.

2. CAA COMPLIANCE COMMITTEE

The CAA Board of Directors shall appoint the Medical Compliance Officer for all CAA clinical sites. The CAA Board of Directors may also appoint physician(s) at each clinical site as Site Compliance Coordinators. Site Compliance Coordinators will work with the Medical Compliance Officer to ensure that compliance policies and procedures are followed appropriately at each CAA clinical site.

CAA's Compliance Committee which will have direct oversight of the CAA Medical Billing Compliance Plan. The committee shall consist of the Medical Compliance Officer, CAA's Director of Human Resources, and Site Compliance Coordinators. The Medical Compliance Officer shall serve as Chair of the Committee. The Committee shall meet at least semi-annually, or at the discretion of the Chair.

3. REPORTING OF COMPLIANCE CONCERNS

CAA is dedicated to providing an environment of honesty, integrity, and trust. Anyone with questions and/or concerns about legal or ethical issues should address them in any one of the following ways:

a. For CAA clinical sites, questions and/or concerns may be communicated directly to the Site Compliance Coordinator for that site, or to the Medical Compliance Officer.

b. For CAA clinical sites and the CAA corporate office, questions and/or concerns may be communicated directly to the Medical Compliance Officer and CAA Director of Human Resources.

c. For CAA clinical sites and the CAA corporate office, questions and/or concerns may be communicated directly to the CAA Compliance Hotline, at 804-461-3883 or by sending an email to Compliance@caa-va.com.

All information discussed through any of the communication channels noted above will be kept confidential to the extent possible, and can be reported anonymously. Follow-up to your questions or concerns is mandated by this policy.

The CAA Compliance Hotline is a resource for all employees who may be confronted with legal or ethical issues in areas such as billing, proper accounting and record keeping, and governmental regulations. The Hotline is operated by an external company and staffed by employees who are not employed by CAA. The CAA Compliance Committee is notified of these calls.

The CAA Director of Human Resources will advise the CAA Compliance Committee of all questions and/or concerns within 72 hours.

Employees who report in good faith possible compliance issues shall not be subjected to retaliation or harassment as a result of the report. Concerns about possible retaliation or harassment should be reported to the CAA President or the Director of Human Resources.

4. EDUCATIONAL ACTIVITIES AND ORIENTATION OF NEW EMPLOYEES

Compliance educational activities and orientation of new employees will be conducted by the Medical Compliance Officer or his/her designee and in coordination with the CAA Compliance Committee. The Site Compliance Coordinator, in conjunction with the CAA Compliance Committee, will conduct periodic compliance meetings at each site. In addition, the Medical Compliance Officer, in conjunction with the CAA Compliance Committee, will ensure that annual compliance reinforcement training is conducted for employees either on-site or via e-learning options. Each Site Compliance Coordinator will maintain a copy of the compliance manual at their site. In addition, the manual will be available electronically via CAA's password protected web portal.

Documentation of each CAA employee's participation in all compliance educational activities and new employee orientation will be centrally maintained by Human Resources to ensure the requirements of the compliance program are being met.

CAA also educates employees on important compliance topics via periodic educational bulletins. Employees are required to review these bulletins and comply with any guidance or instructions provided.

5. REVIEW OF BILLING PRACTICES

a. Chart Monitoring and Site Visits

i. At times deemed appropriate by the CAA Compliance Committee, but no less than bi-annually, CAA's medical billing company, at the direction of the CAA Compliance Committee, will review charts of each clinical provider. It is the goal of CAA to review a minimum of five (5) medical records per provider at the time of the audit. CAA may conduct such reviews with the guidance and direction of

CAA's legal counsel. In such cases, CAA's medical billing company's personnel and CAA Compliance Committee staff will work at the direction of the attorney and will be responsible for maintaining documentation and other information in a confidential manner as directed by legal counsel.

ii. Periodic site visits will be conducted at each clinical site by the Medical Compliance Officer and/or his designee.

b. Other Monitoring and Reporting

CAA will work in coordination with CAA's medical billing company to obtain reports to assist CAA in its compliance efforts. Site Compliance Coordinators will be provided the compliance reports and will be responsible for using the information to educate employees and implement necessary changes to documentation and other practices, when applicable.

For CAA clinical sites: All audit findings will be presented to the Medical Compliance Officer and the CAA President through the CAA Compliance Committee. It is the goal of CAA that these audit findings will then be presented to the CAA employees of the audited site within approximately 30 days of the completion of the audits by the Medical Compliance Officer and/or the Site Compliance Coordinator.

The CAA Compliance Committee will submit a quarterly report to the CAA Board of Directors with regard to CAA's auditing and monitoring activities.

c. Post-Audit Education

Based on the audit outcomes, it is the goal of CAA that post-audit education will occur with all employees of the audited site within approximately 30 days after the audit has been completed. Additionally, if the CAA Compliance Committee determines that specific clinical provider(s) require corrective action, they will make that recommendation to the CAA Board of Directors and the Director of Human Resources. If the CAA Board of Directors agrees with the Committee's assessment, then that clinical provider must attend an educational session to address the specific issues identified for correction within the time period specified by the CAA Board of Directors.

Based on the results of its auditing and monitoring activities, CAA will undertake corrective action which it deems appropriate under the circumstances. This may include such actions as education of employees, employee corrective action as discussed below, expanded audits, development of policies, repayment of funds or other actions.

d. Corrective Action

The Medical Compliance Officer, pursuant to the approved CAA Compliance Policies and Procedures and in consultation with the CAA Board of Directors, will be responsible for imposing the appropriate remedies and sanctions when compliance problems occur with employees of CAA. The existing remedial and disciplinary mechanisms for violations of billing compliance policies include but are not limited to: letters of counseling, letters of reprimand, suspension without pay, and termination. Nothing in this policy alters the status of at-will employees.

6. CAA COMPLIANCE POLICIES

As part of CAA's ongoing compliance efforts, CAA has adopted compliance policies for employees to follow. These policies may change over time and will be periodically reviewed and updated, when necessary.

a. General Overview of the Civil False Claims Act

CAA recognizes that the submission of false claims for health care services is prohibited by several different laws. A "false" claim generally includes a claim that does not conform to Medicare (or other program or payor) requirements for reimbursement. Submission of false claims may result in civil and/or criminal penalties.

The Civil False Claims Act prohibits the knowing submission of false or fraudulent claims for payment to the United States, the knowing use of a false record or statement to obtain payment on a false or fraudulent claim, or a conspiracy to defraud the United States by having a false or fraudulent claim allowed or paid. Violation of the civil False Claims Act may result in substantial civil monetary penalties. In 2009, the False Claims Act was amended so that liability is extended to include any false or fraudulent claim for government money whether or not the claim is actually presented to a government official or employee.

The Department of Justice (DOJ) enforces civil and criminal penalties associated with false claims, and the Office of the Inspector General (OIG) has the authority to exclude providers from federal health care programs. Authorities do not need to prove specific intent of a violation. Civil penalties may range from $5,500 to $11,000 per claim, plus or minus three times the damage sustained by the government agency. In addition, convicted providers may be excluded from Medicare and Medicaid programs.

CAA employees should understand that false claims exposure can be triggered by submitting claims that a provider knew or reasonably should have known were false. This can include submitting a claim with deliberate ignorance or reckless disregard for the truth or falsity of the information. CAA employees are responsible for using good faith efforts to provide accurate and truthful information for billing purposes.

b. Compliance Focus Areas

i. Employee/Contractor Screening:
CAA recognizes the importance of employee and contractor screening and has implemented a policy with regard to this subject matter. *See Compliance Policy No. 1 attached in Appendix A.*

ii. Anesthesia Time:
As part of its compliance activities, CAA has implemented a policy addressing anesthesia time. *See Compliance Policy No. 2 attached in Appendix A.*

iii. Medical Direction:
As part of its compliance activities, CAA has implemented a policy addressing medical direction billing and documentation requirements. *See Compliance Policy No. 3 attached in Appendix A.*

iv. Personal Performance:
As part of its compliance activities, CAA has implemented a policy addressing personal performance. *See Compliance Policy No. 4 attached in Appendix A.*

v. Concurrency:
Concurrency is measured with regard to the maximum number of cases that a physician is involved in during the same time periods. It is not dependent on each case involving, for example, a Medicare patient. As part of its efforts to oversee compliance with regard to concurrency requirements, CAA's medical billing company utilizes specific software designed to check concurrency to ensure appropriate billing of CAA's claims.

vi. Post Operative/Acute Pain Management:
As part of its compliance activities, CAA has implemented a policy addressing billing and documentation requirements for post-operative pain management services. *See Compliance Policy No. 5 attached in Appendix A.*

7. GOVERNMENT/THIRD PARTY PAYOR INVESTIGATIONS

It is CAA's policy to comply with the law and to cooperate with any reasonable demand made in a government investigation. In cooperating with these government demands, however, it is imperative that CAA's legal rights, and those of its employees, are fully protected to the extent of the law. It is therefore CAA's policy that if any employee receives an inquiry, subpoena, or other legal document regarding or relating in any way to CAA's business, whether at home or in the workplace, from any governmental agency, CAA requests that the employee notify the Medical Compliance Officer immediately. If an employee is visited at home by a governmental agent concerning or relating in any way to CAA, the employee is legally entitled to ask the agent to return at a later time, and should immediately contact the Medical Compliance Officer to discuss the matter. CAA will arrange for its legal counsel to accompany the employee to any government visit or interview. CAA strongly prefers that employees accept legal representation for these governmental visits.

CAA expects that its employees will notify the Medical Compliance Officer if the employee believes that the government has initiated an investigation with regard to CAA or any party affiliated with CAA.

8. REVIEW AND APPROVAL OF CAA MEDICAL BILLING COMPLIANCE PLAN

This document, as well as other written policies and procedures for billing activities, will be maintained by the CAA Medical Compliance Officer. It will be reviewed annually by the Medical Compliance Officer in order to identify any needed modifications as well as specific compliance objectives during the succeeding year. The plan will be reviewed and approved by the CAA President. Revised plans will be presented to the CAA Board of Directors and CAA's Compliance Committee once they have been approved by the CAA President.

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Policy Type and No: Compliance Policy No. 1

Subject: **Employee Screening**

Effective Date: January 4, 2013

Revised: July 1, 2014

POLICY:

This policy describes CAA's responsibility in preventing employment, contracting with, or doing business with any individuals or entities providing (or in any way involved with) federally reimbursed services if those individuals or entities have been excluded, suspended, debarred, or otherwise deemed ineligible to participate in any federally funded health care program. To this end, CAA shall not knowingly employ or consult with, with or without pay, individuals who have been listed by a federal agency as debarred, suspended, or otherwise ineligible for federal programs or who have been convicted of a criminal offense related to healthcare.

SCOPE:

Applicable to all CAA and affiliated company staff members, consultants, contract workers and temporary staff ("Relevant Covered Persons").

APPLICABLE REGULATIONS and GUIDELINES:

Department of Health and Human Services, Office of Inspector General – Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs. (Issued May 8, 2013)

RESPONSIBILITIES:

All CAA employees and applicable contractors are responsible for adhering to procedures as described. All staff must receive training on all pertinent CAA policies and procedures, and must adhere to all conditions as documented.

PROCEDURE:

Federal laws restrict health care providers or other entities from employing or entering into contracts with excluded individuals or entities to provide services or items that may be billed to federally funded programs. These laws are designed to ensure that federally funded health care programs only pay for items or services provided by reputable individuals or entities.

COMMONWEALTH
ANESTHESIA
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Policy Type and No: Compliance Policy No. 1 *(continued)*

CAA must ensure that appropriate screening is performed by maintaining screening documentation. Screening will be performed periodically, in accordance with the Office of Inspector General – Special Advisory Bulletin on the Effect of Exclusion from Participation in Federal Health Care Programs.

CAA is subject to overpayment liability for any items or services furnished by an excluded person, for which reimbursement is received, and maybe be subject to Civil Money Penalties (CMP) imposed by OIG for misconduct related to federal health care programs.

Employees:

- CAA must not employ or continue to employ any individual who is excluded, debarred, suspended, or otherwise deemed ineligible to participate in federal health care programs, or convicted of a criminal offense related to a federal health care program.
- Employees must immediately disclose to Human Resources and CAA's Medical Compliance Officer if they are, or become, ineligible to participate in federal health care programs, or a state Medicaid program.
- The Company will ensure that background checks are performed against the HHS/OIG List of Excluded Individuals/Entities database ("LEIE database") for all applicable prospective employees, and will perform periodic reviews of current employees.
- CAA employees to be screened include those who, based on position description, provide or are involved in providing items or services directly or indirectly payable by a federal health care program. For CAA, this includes healthcare providers, administration, account support, billing, and IT staff.

Contractors and Vendors:

- CAA may not do business with any contractor or vendor that is ineligible to participate in federal health care programs.
- The company will periodically screen against the LEIE database all contractors and vendors who provide or are involved in providing items or services directly or indirectly payable by a federal health care program.
- CAA will require all applicable contractors and vendors, as a condition of doing business with CAA, to warrant that they are not an Ineligible Person and are not currently excluded from participation in any federal health care program.
- CAA will require agencies providing Locum Tenens employees to CAA to perform background checks against the LEIE database.

Policy Type and No: Compliance Policy No. 2

Subject: **Anesthesia Time**

Effective Date: May 8, 2013

Overview:

Anesthesia time starts when the anesthesiologist or medically directed qualified anesthetist (all collectively referred to as anesthesia provider) begins to prepare the patient for anesthesia care in the operating room or equivalent area and ends when the anesthesia provider is no longer in personal attendance, i.e. when the patient may be safely placed under post-operative supervision. For purposes of anesthesia time calculation, a patient may be considered safely placed under post-operative supervision after the anesthesia provider transports the patient to the Post-Anesthesia Care Unit ("PACU"), or other applicable unit, stabilizes the patient, and gives a report to the appropriate PACU or other applicable staff.

Medicare also permits anesthesia groups to report discontinuous time by adding blocks of time around a break in continuous anesthesia care as long as there is continuous monitoring of the patient within the blocks of time. According to the Federal Register commentary, the discontinuous time provision was enacted to take into account those instances in which there is a break in the continuous presence of the anesthesiologist or CRNA in providing the normal course of administration of an anesthetic (i.e., establishment of venous access; acquisition of initial monitoring information; induction of anesthesia; maintenance of anesthesia; and conclusion of anesthesia attendance). For example, discontinuous time could occur when a regional or block technique is used, resulting in a break between induction of anesthesia and maintenance of anesthesia in which the patient can be safely observed by non-anesthesia personnel. It is not expected that discontinuous time would be used on a routine basis.

Anesthesia time for placement of invasive lines or regional blocks used for postoperative analgesia is not billable if those lines or regional blocks are placed prior to the induction of general anesthesia. These procedures are billed separately using procedural, non-timed charges. Note, however, if an invasive line or regional block is placed during a general anesthetic the time does not need to be subtracted and the procedure can still be charged separately.

With regard to regional blocks used as the primary anesthetic in the surgical case, time required to place the block is billable as this constitutes preparing the patient for anesthesia. Please note that the block is not a separately billable procedure in these circumstances.

Services that are included in the anesthesia base unit cannot be counted towards time. The anesthesia base unit is defined to mean the value for each anesthesia code that reflects all activities other than anesthesia time. These activities include usual pre-operative and post-operative visits, the administration of fluids and blood incident to anesthesia care, and monitoring services.

Policy:
It is the policy of CAA that its anesthesia providers comply with the following guidelines:

1. Using the above rules, report actual minutes, not rounded minutes, in the patient's anesthesia record and document time in a legible manner.

2. If discontinuous time is used, multiple start and stop times should be clearly recorded.

3. Make sure to corroborate your anesthesia times and to chart vital signs to support anesthesia times. For example:

   —For start: "In OR", "IV sedation", "Induction started", "Epidural block", etc.
   —For end: "PACU out", "Report to R.N.", "Anesthesia out", etc.

4. Placement of invasive monitoring devices (arterial lines, central venous lines, and Swan Ganz catheters), transesophageal echocardiography and epidurals and nerve block procedures performed for post-operative pain (not intended to provide anesthesia for a surgical procedure) are separately reportable from an anesthesia service. Time spent on these procedures, if performed after induction of anesthesia for the primary surgical procedure and before the end of anesthesia time, does not need to be deducted from the reported anesthesia time. If the anesthesiologist performs these procedures outside of that period, however, time should not be included in reported anesthesia time.

Sources: 42 CFR 414.46
ASA resources
Medicare Claims Processing Manual Chapter 12 Section 50

Policy Type and No: Compliance Policy No. 3

Subject: **<u>Medical Direction</u>**

Effective Date: May 8, 2013

Revised: July 1, 2014

Overview:

Per 42 CFR Sections 415.110, medical direction requires that for each patient the anesthesiologist fulfill the following seven (7) specific responsibilities:

1. Performs the pre–anesthetic exam and evaluation
2. Prescribes the anesthesia plan
3. Participates in the most demanding aspects of the anesthesia plan including, if applicable, induction and emergence
4. Ensures that any procedures in the anesthesia plan that he/she does not perform are performed by a qualified individual
5. Monitors the course of anesthesia at frequent intervals
6. Remains physically present and available for immediate diagnosis and treatment of emergencies
7. Provides indicated post-anesthesia care

Certain other services or activities are allowed while medically directing concurrent anesthesia procedures. CMS has stated that the medically directing anesthesiologist may perform other duties concurrently to include:

- Addressing an emergency of short duration in the immediate area
  - Example: an emergency intubation
- Administering an epidural or caudal anesthetic to ease labor pain
- Performing periodic rather than continuous monitoring of an obstetrical patient
- Receiving patients entering the operating suite for the next surgery
- Checking on or discharging patients in the post anesthesia care unit
- Coordinating scheduling matters
- Placing invasive lines and regional blocks in the holding area or post anesthesia care unit for pre- or post-surgical patients

According to a CMS letter dated December 30, 2004, Dr. Hickman, Medical Director of the Medicare Integrity Program for the Part B Carrier, also opined that it would be permissible for an anesthesiologist to place invasive lines and regional blocks in the holding area for patients without violating the medical direction requirements. Medicare also permits anesthesiologists to share medical direction responsibilities within a group.

With regard to documentation of medical direction, 42 CFR 415.110 provides that the physician alone inclusively documents in the patient's medical record that the conditions set forth in paragraph (a)(1) have been satisfied, specifically documenting that he or she performed the pre-anesthetic exam and evaluation, provided the indicated post-anesthesia care, and participated in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence.

If the Anesthesiologist leaves the immediate area of the operating suite for long periods of time, spends "extensive time" on an emergency case, or is otherwise unable to respond to a surgical patient's needs, his/her services become supervisory in nature and no longer meet the criteria for medical direction. In this instance, CAA expects that the anesthesiologist will sign over his or her medical direction responsibilities to an available anesthesiologist.

Policy:
It is the policy of CAA that its anesthesia providers comply with the following guidelines:

1. Follow the above-noted rules in the performance of medical direction anesthesia services;

2. CAA anesthesiologists are responsible for personally documenting the services and fully documenting that all applicable requirements of medical direction have been met. Documentation must be legible and it should be clear to an outside party that the requirements were met.

3. For those cases in which care is transferred, documentation of the hand-off of medical direction responsibilities should be evident on the record.

Source:
42 CFR 415.110;
42 CFR 414.46;
November 25, 1997 letter from Terrence Kay, Director of Physician and Ambulatory Care, HCFA, to the American Society of Anesthesiologists;
December 30, 2004 letter from Dr. Hickman, Medical Director of Medicare Integrity Program, on CMS letterhead
Medicare Claims Processing Manual Chapter 12 Section 50

Protocol to: Compliance Policy No. 3 *(continued)*

Documentation Guidelines for Medical Direction

The final rule in the Tax Equity and Financial Responsibility Act (TEFRA, 1998) requires physicians to meet seven requirements for medical direction of anesthesia services.

It is the goal of CAA that review of the seven requirements will be performed on every anesthesia record submitted for billing using the following guidelines:

- The anesthesia providers (MD/DO/CRNA) are ultimately responsible for the anesthesia records and charges submitted. Careful review of the record for legibility, accuracy, and completeness is mandatory.

- The Site Compliance Coordinator of each clinical site is responsible for coordinating all compliance and educational activities through the CAA Compliance program.

- It is the responsibility of a provider who knows that the medical direction requirements were not satisfied for a particular service to identify this for billing purposes as described further in this protocol so that CAA's medical billing company can submit the claim in the appropriate manner.

- CAA's medical billing company will review each anesthesia record for documentation of medical direction.

Protocol to: Compliance Policy No. 3 *(continued)*

Failed Medical Direction-Billing Protocol

Failed Medical Direction occurs when any of the seven steps of medical direction are not provided or when a non-allowed activity is performed during medical direction. When this occurs, the affected case(s) will not be billed as medically directed.

If an anesthesia provider is aware of a break in medical direction, the following steps should be followed:

- If any of the seven steps of medical direction were performed but not adequately documented, appropriate corrections to the medical record must be completed, adhering to the facility's guidelines and any applicable policy for amending the medical record.
- If any of the seven steps of medical direction were not performed, this becomes a failed medical direction case. The anesthesiologist should make an appropriate notation on the anesthesia record and/or contact CAA's medical billing company to inform them of same. The case will then be billed appropriately.

Breaches in medical direction will be trended by CAA's medical billing company and reported to CAA's Medical Compliance Officer and the medical billing company's Medical Compliance Officer and Administrative Compliance Officer.

Concurrency

Concurrency refers to two distinct and related situations:

1. Concurrency refers to the number of anesthetics being medically supervised or medically directed by an anesthesiologist. To be billed as medical direction, the anesthesiologist must be involved in four or less anesthetics and meet the seven steps of medical direction.

   If at any time during the anesthetics greater than four cases overlap, then all of the cases that physician is involved in at that time will be billed as medically supervised.

2. In addition, invalid concurrency refers to a physician working in two places at the same time without having a qualified individual working with him or her. It also refers to a CRNA being in two places at the same time. Examples include a physician personally performing an anesthetic while medically directing or a CRNA being on two anesthetics with overlapping times without clear documentation of relief. These types of invalid concurrency lapses will not be billed until there is appropriate resolution by the Medical Compliance Officer in consultation with the provider and CAA's medical billing company.

CAA's medical billing company will monitor and send periodic compliance reports to CAA's Medical Compliance Officer and the medical billing company's Medical Compliance Officer and Administrative Compliance Officer.

The Centers for Medicare and Medicaid Services (CMS) seven requirements expect the Attending Anesthesiologist to perform and document the following:

1. **"Perform the pre-anesthetic examination and evaluation."**
   It is the policy of CAA that for each patient the anesthesiologist must perform and document a pre-anesthesia evaluation and exam within 48 hours prior to surgery or a procedure requiring anesthesia. Documentation of the pre-anesthesia portion may be on a printed pre-anesthesia form, electronic medical record, or in the progress notes.

   Pre-Anesthesia documentation should include the evaluation and exam performed by an anesthesiologist culminating in an ASA score. CAA has adopted the ASA Physical Classification System guidelines as modified by The Cleveland Clinic Foundation (2010).

   It is the internal policy of CAA that the following must be performed and documented:

   - The **evaluation** must include documentation of the patient's condition: age, mental status (if appropriate), any physical disabilities or co- morbid conditions that may affect the administration of the anesthetic, along with review of the patient's medical records where applicable.

   - The documentation of an appropriate **exam** should include the following: vital signs, airway, heart, lungs or other pertinent exam/review. It is CAA policy that stating "performed exam" is not sufficient: the anesthesiologist must note findings. The assignment of an ASA Physical status level must be documented.

2. **"Prescribe the anesthesia plan."**
   The anesthetic plan (prescription) is determined by the anesthesiologist based on the evaluation and examination of the patient and the procedure being performed. This can be documented in the same section as the pre-anesthesia evaluation if an anesthesiologist performs the initial evaluation. If the initial evaluation is performed by a nurse practitioner, credentialed RN, or CRNA, the anesthesia plan must be discussed, prescribed, and documented by the anesthesiologist medically directing the case. The original anesthesia plan can be changed at the time of actual procedure if deemed medically necessary with appropriate documentation. For example: "original prescription was for a regional but due to the patient's condition changed to general anesthesia (GA)".

Prescription of Anesthetic Plan documentation must include documentation by the anesthesiologist on whether the planned anesthesia is GA, Regional or MAC. Note that it is the policy of CAA that stating “formulated the anesthesia plan” by itself is not sufficient documentation.

A copy of the pre-anesthetic evaluation will be sent with the anesthesia intraoperative record to CAA’s medical billing company for review. The medical coders at CAA’s medical billing company will look for completeness of evaluation, signature of an anesthesiologist, ASA status, date within 48 hours of anesthetic, and documentation of a specific anesthesia plan.

3. "**Participate in the most demanding aspects of the anesthesia plan including, if applicable, induction and emergence.**"
   During general anesthetics, the anesthesiologist should document his or her presence and availability by appropriately documenting in chronological fashion participation in induction and emergence.

   Induction is defined as a continuum that begins with the administration of medications until “the establishment of a depth of anesthesia adequate for surgery”. For purposes of documentation, induction will include the time from the administration of IV agents, or initiation of inhalation agents, until the patient is ready for surgical incision. It is the policy of CAA that a separate preprinted statement “present for induction” must be signed or initialed by the anesthesiologist to demonstrate this element.

   Emergence is defined as a continuum that begins as the anesthetic level is being reduced until the patient is stable in the PACU. Monitoring of the patient during emergence can occur at any time in the process of emergence. It is the policy of CAA that a separate preprinted statement “present for emergence” must be signed or initialed by the anesthesiologist to demonstrate this element.

   It is the policy of CAA that pre-signing presence of induction or emergence is not an acceptable practice and is prohibited.

   During anesthetics that are not considered to be general, (i.e., regional and/or MAC anesthetic), there is no period of induction or emergence.

4. "**Ensure that any procedures in the anesthesia plan that he or she does not perform are performed by a qualified individual.**"
   Although the only specific documentation required in each patient's record is the names and credentials of the providers, records of current licensure and training certification must be maintained. Knowledge of the individual's skill set and training is required. On an annual basis, the review of provider credentialing will be performed by the Medical Compliance Officer in collaboration with the Human Resources Department.

5. "**Monitor the course of anesthesia administration at frequent intervals.**"
   CAA physicians are responsible for monitoring at frequent intervals and documenting such monitoring. As CMS has not specifically defined this term, it is the internal policy of CAA, based on standards in the industry, that for a general anesthetic lasting ninety (90) minutes or less, unless otherwise medically indicated based on the clinical judgment of the physician, the documentation of presence during induction and at some point during emergence will be sufficient. If the anesthetic lasts longer than ninety (90) minutes, unless more frequent monitoring is medically indicated based on the clinical judgment of the anesthesiologist, the anesthesiologist should document visits to the operating room in approximately 1-2 hour intervals. This standard of documenting visits applies to regional and MAC cases lasting longer than ninety (90) minutes. CAA physicians are responsible for clearly and consistently documenting both paper and electronic anesthesia records with the time that this monitoring occurs.

6. "**Remain physically present and immediately available for diagnosis and treatment of emergencies.**"
   All anesthesia records will contain a statement “Anesthesiologist immediately available and present for the most demanding portions of anesthesia plan.” The anesthesiologist is responsible for signing this statement in all cases in which he/she fulfills the requirements.

   CAA has adopted the definition of “immediately available” as approved by the ASA House of Delegates on October 17, 2012 as follows: “A medically directing anesthesiologist is immediately available if s/he is in physical proximity that allows the anesthesiologist to return to re-establish direct contact with the patient to meet medical needs and address any urgent or emergent clinical problems. These responsibilities may also be met through coordination among anesthesiologists of the same group or department. Differences in the design and size of various facilities and demands of the particular surgical procedures make it impossible to define a specific time or distance for physical proximity.”

If an anesthesiologist leaves the facility or signs off to another anesthesiologist, there must be a clearly documented hand-off on the anesthesia record. In order to address these hand-off situations, all anesthesia records, including general, regional, and MACs will have a statement that indicates that the relieving anesthesiologist has assumed responsibility for care at a particular time, was immediately available, and participated in the most demanding aspects of anesthesia plan. This statement will be signed by the relieving anesthesiologist.

The relieving anesthesiologist is responsible for filling in and signing this statement. This should be used when the medically directing anesthesiologist is relieved by another medically directing anesthesiologist.

7. "**Provide indicated post-anesthesia care.**"
   The anesthesiologist must personally document indicated post-anesthesia care he/she has provided. Standing orders in the post-anesthesia care unit (PACU) are sufficient but should be dated and signed by an attending anesthesiologist.

   The post-anesthesia evaluation must be completed and documented within 48 hours of any surgery involving general, regional, or monitored anesthesia in both inpatient and outpatient settings. The 48-hour period begins when the patient is moved into the designated recovery area. The evaluation **cannot** begin immediately upon arrival to the recovery area and cannot occur until after the patient has sufficiently recovered from the effects of anesthesia so as to participate in the evaluation (e.g., answer questions appropriately, perform simple tasks such as moving extremities purposely).

Policy Type and No: Compliance Policy No. 4

Subject: **Personal Performance**

Effective Date: January 4, 2013

Overview:

For those cases in which the anesthesiologist is performing the service alone and billing the service with the AA modifier, the anesthesiologist must be continuously and personally present throughout the entire procedure with the patient. The anesthesiologist who is personally performing the case cannot be involved in providing any other services while he/she is personally performing the case.

Policy:

It is the policy of CAA that its anesthesiologists comply with the following guidelines:

1. Follow the above-noted rules for personal performance of anesthesia services.

2. CAA anesthesiologists are responsible for personally documenting the services rendered. Documentation must be legible and it should be clear to an outside party that the requirements were met.

3. For those cases in which care is transferred, documentation of the hand-off of responsibility should be evident on the record.

Source: 42 CFR 414.46;
Medicare Claims Processing Manual Chapter 12 Section 50

Policy Type and No: Compliance Policy No. 5

Subject: **Post-Operative Pain**

Effective Date: January 4, 2013

Overview:

In general, Medicare and other payors permit separate billing of post-operative pain management services such as epidurals and blocks if the procedures are done for post-operative pain management and not for use of the anesthetic during the surgical case. The critical distinction that justifies separate payment is that the mode of anesthesia provided for post-operative pain relief is different from the mode of anesthesia use for the surgical procedure.

The ASA provides this example: *"...if an interscalene nerve block is placed prior to shoulder surgery to effect prolonged post-operative analgesia, then a general anesthetic would have to be used for the actual shoulder surgery rather than simply I.V. sedation in order to properly report the regional block separately. In this setting, if the patient was provided a block and only sedation was added, then it would be clear that the interscalene block was part of the primary anesthetic rather than a mode of post-operative analgesia."*

Proper documentation of the procedure and medical necessity of the service must also be present.

Policy:

It is the policy of CAA that its anesthesia providers comply with the following guidelines:

1. Follow the above-noted rules with regard to post-operative pain management services.

2. Clearly document that the provision of the pain control procedure was for post-operative pain management and was separate from the mode of anesthesia used for the surgical case.

3. Document that the post-operative pain control was requested by the surgeon and discussed with the surgeon, if documentation from the surgeon is not present in the record.

Sources: ASA materials
Medicare Part B Policy Changes, HCFA Office of Payment Bureau Program Development, Memorandum May 29, 1992