

Compliance Update 2015

SAAA 2015 Annual Meeting

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Disclosures

- ◆ In private law practice
 - Advise clients on regulatory compliance & transactions
- ◆ Objectives
 - Describe issues the HHS OIG has listed as a focus area in its FY 2013 Work Plan
 - Identify other compliance risk areas for anesthesia practices

Overview

- ◆ Compliance questions in academic settings
 - Who can write a post-op note?
 - Billing when coverage changes
 - Breaks
 - “Independence” for resident education
- ◆ Asking for CMS guidance
- ◆ And more

Acronyms Used

- ◆ CAC - Carrier Advisory Committee
- ◆ CoPs - Conditions of Participation for Hospitals (to participate in Medicare)
- ◆ HHS - Dep’t of Health & Human Services
- ◆ MAC - Medicare Administrative Contractor
- ◆ NCCI - National Correct Coding Initiative
- ◆ NGS - National Gov’t Services
- ◆ OIG - HHS Office of Inspector General

Reviewing the Rules

Teaching Rule (Medicare)

- ◆ 100% of allowance if teaching anesthesiologist involved in
 - Single case with a resident,
 - Two concurrent cases involving residents, or
 - Single anesthesia case w/a resident concurrent to another case paid under medical direction rules

Teaching Rule (Medicare)

- ◆ Teaching anesthesiologist, or different anesthesiologists in same group, must
 - Be present during all critical or key portions of the case
 - Be immediately available for entire case
- ◆ Documentation in record must indicate both presence for all critical/key portions & immediate availability

7 Steps of Medical Direction

- ◆ Perform preanesthetic exam
- ◆ Prescribe anesthetic plan
- ◆ Personally participate/most demanding parts (induction/emergence, if applicable)
- ◆ Ensure performance by qualified anesthetist
- ◆ Monitor at frequent intervals
- ◆ Remain physically present/available for immediate diagnosis
- ◆ Provide indicated post-anesthetic care

Risk Areas: Medical Direction

- ◆ Medical direction:
 - Not satisfying 7 steps of medical direction
 - Not documenting all 7 steps
 - Immediate availability
 - Documentation of handoffs
 - Breaks

Teaching Rule (Medicare)

- ◆ If, due to facts, teaching cases convert to medical direction (when >2):
 - Teaching anesthesiologist may not have
 - » Performed preanesthetic assessment &
 - » Prescribed the anesthetic plan
 - Would not satisfy medical direction
 - » Though teaching anesthesiologist present for all key portions

Post-Op Note

- ◆ Who can write a post-op note?
 - Question: Under what regulatory scheme?
 - » Medicare billing rules
 - Teaching rule
 - Medical direction
 - » Hospital CoPs – postanesthesia evaluation

Post-Op Note

- ◆ Medicare teaching rule (billing):
 - On/after 1/1/2010, 100% of Medicare PFS allowance paid if teaching anesthesiologist is involved in training up to 2 residents
 - » Teaching anesthesiologist must be present during all critical or key portions of the anesthesia service or procedure involved

Post-Op Note

- ◆ Medical direction rule (billing):
 - Seven steps of medical direction
 - Anesthesiologist must provide indicated post-anesthesia care
 - » Consider documentation

Post-Op Note

- ◆ Hospital CoPs - Postanesthesia evaluation completed & documented by individual qualified to administer anesthesia
 - Anesthesiologist
 - MD or DO (other than an anesthesiologist)
 - Dentist, oral surgeon, or podiatrist qualified under State law to administer anesthesia
 - CRNA
 - AA

Post-Op Note

- ◆ Hospital CoPs - Medical Record Entries
 - “When State law &/or hospital policy requires that entries in the medical record made by residents or non-physicians be countersigned by supervisory or attending medical staff members, then the medical staff rules & regulations must address counter-signature requirements and processes”

State Operations Manual, App. A, Sec. A-0450 (42 CFR § 482.24(c)(1))

Changes: When Cases No Longer Are Teaching Cases

Changes in a Case

- ◆ Billing when coverage changes
 - From 1-on-1 (or 1-on-2) w/residents
 - » To one-on-three or four with CRNAs
 - » No longer eligible for “teaching” rule
 - » May convert to medical direction, but
 - Always must consider if have satisfied medical direction rules in each case

Changes in a Case

- ◆ Billing when coverage changes
 - Need to look at specifics of each case to determine what services are billable
 - » When does case convert?
 - How much of case has been completed before conversion?
 - » How many concurrent cases?
- ◆ No one easy answer

Breaks & Temporary Relief

Breaks

- ◆ If one-on-one
 - With either a CRNA or resident
 - Can step in & provide break relief
 - » No effect on medical direction
 - » No effect on teaching rule req'ts

Breaks

- ◆ Issues arise w/concurrent cases
 - For teaching cases:
 - » “The teaching anesthesiologist (or another anesthesiologist with whom the teaching physician has entered into an arrangement) must be immediately available to furnish anesthesia services during the entire procedure.”

Medicare Claims Processing Manual 100.1.2.A.4

Breaks

- ◆ CMS (Nov. 2009):
 - “Thus, different anesthesiologists in the same anesthesia group practice can be considered the teaching physician for purposes of the statutory requirement that the teaching anesthesiologist be present at the key or critical portions of the anesthesia service.”

Breaks

- ◆ If another teaching anesthesiologist is available to oversee Case 2, an anesthesiologist may be able to provide a break in Case 1 w/resident
- ◆ For whom is a break provided?
 - Resident?
 - CRNA?

Breaks for Colleagues

- ◆ Ordinarily medically directing physician cannot provide a "break" for a CRNA
 - Would be personal performance
 - ▶ Cannot medically direct & personally perform at the same time
 - Issue: How to be immediately available?
 - ◆ Best approach:
 - Have same category of provider relieve
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Breaks for Colleagues

- ◆ Has your MAC provided flexibility on breaks?
 - *E.g.*, NGS & Palmetto GBA policy on "Medical Direction & Temporary Relief"
 - NGS & Palmetto allow 3 ways to meet req't of uninterrupted immediate availability
 - ◆ Absent MAC policy, breaks "break" medical direction
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NGS & Palmetto: Breaks & Temporary Relief

- ◆ Option 1:
 - Second anesthesiologist, not medically directing > 3 concurrent procedures, may assume temporary medical direction responsibility for relieving anesthesiologist
 - Must document transfer of responsibility on medical record
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NGS & Palmetto: Breaks & Temporary Relief

- ◆ Option 2:
 - Policy & procedure may require that the relieved provider remain in immediate area & be available "to immediately return" to his/her case in event relieving anesthesiologist is required to be elsewhere
 - Must have adequate communications mechanisms
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NGS & Palmetto: Breaks & Temporary Relief

- ◆ Option 3:
 - Policy & procedure require that a specified anesthesiologist (*e.g.*, Anesthesiologist of the Day or OR Dir.) remains available at all times to provide substitute medical direction services for anesthesiologists providing relief to anesthesia providers; AND
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NGS & Palmetto: Breaks & Temporary Relief

- ◆ Option 3 (continued):
 - This individual (*e.g.*, the OR director) must not personally have ongoing med. dir. responsibilities that would preclude temporarily assuming responsibility for additional case(s)
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Breaks: Practical Questions

- ◆ What is “temporary” relief?
- ◆ How long may a break be?
 - Need to define
 - Needs to be consistent with NGS or Palmetto (or other MAC) guidance
 - Your Department Compliance Committee should address

Breaks: Practical Questions

- ◆ What is immediate availability of the relieved CRNA or resident?
- ◆ Immediately available
 - Geographic immediate availability
 - » Cannot be offsite
 - Practical availability - ability to return
 - » Interruptible

Breaks: Practical Questions

- ◆ How far away can you be & still be immediately available?
 - Need to assess all areas
- ◆ OIG is looking at immediate availability
 - Do not be overly aggressive

Breaks: Practical Points

- ◆ Need to meet medical direction in other concurrent cases
 - Must participate in most demanding portions
 - Need some way to monitor the other concurrent case(s)
 - » And document frequent monitoring in other concurrent case(s)

Resident “Independence”

Resident “Independence”

- ◆ How do programs fulfill ACGME mandate of providing graded responsibility & indirect supervision
 - Without running afoul of CMS mandates for
 - » Supervision - participation in critical portions, and
 - » Documentation of involvement

Resident “Independence”

- ◆ ACGME:
 - “The education must culminate in sufficiently independent responsibility for clinical decision-making & patient care so that the graduating resident exhibits sound clinical judgment in a wide variety of clinical situations & can function as a leader of peri-operative care teams”

Resident “Independence”

- ◆ Two separate sets of rules – different purposes
- ◆ For billing, CMS (& other payors’) rules govern
 - Teaching: Must participate in critical portions of case
 - Medical direction: Similar req’t (most demanding portions); frequent monitoring

Resident “Independence”

- ◆ Bottom line: Must satisfy both
 - “Participating” for teaching can mean being in room to observe & be ready to intervene
 - Is remote monitoring sufficient?
 - » E.g., reviewing monitor or observing through door
 - No guidance – more risk
 - May not be sufficient

Asking for
CMS or MAC
Guidance

Requesting Guidance

- ◆ Be careful what you ask for
 - Clarity is desirable, but a negative response may create hardship
 - Consider previewing issue with
 - » CAC representative
 - » State Component Society
 - » ASA

PACU Delays
&
Anesthesia Time

PACU Delays & Anesthesia Time

- ◆ **Anesthesia time (Medicare):**
 - “Anesthesia time . . . starts when the anesthesia practitioner begins to prepare the patient for anesthesia services and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the beneficiary, that is, when the beneficiary may be placed safely under postoperative care.”

PACU Delays & Anesthesia Time

- ◆ **Issue: What happens when the patient “may be placed safely under postoperative care,” but no PACU bed is available?**
 - Medicare contemplates that the “anesthesia practitioner” is no longer with the patient when the patient may safely be placed under post-op care

PACU Delays & Anesthesia Time

- ◆ **Guiding issue:**
 - Is it medically necessary for anesthesia personnel to remain w/the patient?
 - » Should only bill for time that is medically necessary
 - Should document reason remaining w/patient

PACU Delays & Anesthesia Time

- ◆ **NCCI – In discussing anesthesia time & discontinuous time:**
 - “However, if it is medically necessary for the anesthesia practitioner to continuously monitor the patient during the interval time and not perform any other service, the interval time may be included in the anesthesia time.”
- ◆ **Underscores medical necessity**

Documenting Participation in Emergence

Emergence

- ◆ ***U.S. ex rel. Donegan v. Anes. Associates of Kansas City, PC* (June 9, 2015 WD Mo)**
 - **Claim: Emergence excludes PACU time**
 - » Experts testified that participation in emergence should be in OR
 - » Issue: Did group file false claims by billing for medical direction though “virtually never” participated in emergence in OR?

Emergence

- ◆ Court ruled for group
 - “Defendant defines “emergence” to include the patient’s recovery in the recovery room. Although this may not be the most widely held or most reasonable definition of “emergence,” it is a plausible definition. By extension, Defendant’s view that the regulation is satisfied by seeing the patient in the recovery room is a reasonable interpretation.¹¹”

Emergence

- ◆ Of concern: Ct’s comment that emergence extending to PACU may not be most reasonable or widely held view
- ◆ Ct also emphasized in its footnote:
 - “¹¹ The Court emphasizes it is making no ruling on whether seeing a patient in the recovery room is a reasonable interpretation of step three’s requirement to personally participate in *the most demanding aspects* of emergence.”

Emergence

- ◆ Case points to how even a group that is careful about compliance can end up in a whistleblower action
- ◆ Points to vulnerabilities in gray areas
 - Anesthesia billing involves many gray areas

Other Developments Conclusion

Anesthesia Remains a Focus

- ◆ Anesthesia remains on OIG work plan
 - Can expect more enforcement
- ◆ Whistleblower action v. Vanderbilt University Medical Center pending
 - Trial scheduled for May 2016
- ◆ Other enforcement action in the news

Conclusion

- ◆ Anesthesia billing is complicated
- ◆ There are many questions to which there are no good answers
- ◆ Continue to:
 - Educate staff
 - Require good documentation of services
 - Document decision-making on compliance decisions