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Part B Insider (Multispecialty) Coding Alert

Anesthesia Medical Direction: Work With Your Carrier to Define 'Short Duration' and Meet Criteria

Know whether extra services help or hurt your claim

Your anesthesiologist is medically directing three cases when he's asked to step out and assist with a service for another patient. Is he still able to report the initial cases as medically directed? Here's how to decide.

Count These 'Extra Services' Toward Medical Direction - If They're Quick

Determining whether cases can be coded as medically directed is challenging for almost every coder. Some coders blame the vague terms CMS chose for its seven rules for reporting medical direction.

Then CMS muddied the waters even more by stating that the medically directing anesthesiologist may perform other duties concurrently (sometimes known as the "Six permissible sins" of medical direction). These duties include:

- Addressing an emergency of short duration in the immediate area
- Administering an epidural or caudal anesthetic to a patient in labor
- Performing periodic, rather than continuous, monitoring of an obstetrical patient
- Receiving patients entering the operating suite for the next surgery »
- Checking or discharging patients in the PACU
- Coordinating scheduling matters.

One of the most common questions regarding these "exceptions" is: What constitutes an emergency of short duration? Specific answers might vary from one coder to the next, but the consensus is usually the same: It's a judgment call.

For example, how you interpret "short duration" can depend on the size of the facility in which you work. Can a physician who is helping in the ED or ICU of a large hospital really get back to the OR quickly enough? In some hospitals, the ICU may be very close to the OR. In others, the departments could be in separate wings. It really comes down to a decision the group must make.

Documentation Can Help Support 'Short Duration'

Some services are fairly easy to justify as emergencies of short duration, which means you shouldn't have trouble with reimbursement. Two common examples can be intubation for adults in respiratory arrest and for infants with meconium (31500, Intubation, endotracheal, emergency procedure).

Other examples include treating nearby PACU patients with problems such as hypotension (458.x, Hypotension), respiratory distress (786.09, Dyspnea and respiratory abnormalities, other; 518.82, Other pulmonary insufficiency, not elsewhere classified; or 518.5x, Pulmonary insufficiency following trauma and surgery) or inadequate pain medications.

Including a diagnosis such as respiratory arrest or meconium leaves little doubt to the payer that you're reporting an emergency situation. Be sure to educate your anesthesia providers, however, in terms of which services are accepted as emergencies of short duration while other services that seem similar might not be.

Example: The guidelines state that the physician can administer an epidural or caudal anesthetic to a patient in labor while medically directing several cases. Some coders say their physicians have a hard time realizing that an epidural steroid injection (ESI) which usually takes less time than a laboring epidural - does not constitute "short duration."

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The difference in the two epidural situations is that the ESI is an elective procedure the physician can administer at any time; a laboring epidural cannot be delayed until a three-hour case is finished. (CPT® includes many codes for ESIs, depending on the circumstances. Common ones include 62310, Injection(s), of diagnostic or therapeutic substance[s] [including anesthetic, antispasmodic, opioid, steroid, other solution],... epidural or subarachnoid; cervical or thoracic; 62311, ... lumbar, sacral [caudal]; 64479-64484, various sites for Injection, anesthetic agent and/or steroid, transforaminal epidural).

Consider Setting a Definition of 'Short Duration'

CMS has yet to put anything in writing to explain the time frames associated with procedures of "short duration". If you're trying to define it for your group, consider these perspectives:

- The service should take no more than a minute or two for the anesthesiologist to reach the patient.
- The service should be no longer than the amount of time the patient could survive without oxygen.
- Remember that in anesthesia, an "emergency" is defined as a threat to the patient's life or limb.

Because there's not an official definition or set of parameters for "short duration," some coders believe you should address it yourself. Opinions on whether that's good or bad vary.

Pros: One obvious positive aspect of creating your own definition is that everyone in your group should be on the same page in terms of following the guidelines. Supporters also believe the guidelines could come in handy during an audit. If questions regarding "short duration" come up, you can point to your group's policy and explain that you've developed your own definition or criteria since an official, clear definition does not exist.

Cons: Once you have a written policy, everyone must adhere to that policy exactly. Also consider that carriers might not agree with your rule and that, if you deviate from it in any way, you broke medical direction based on your own policy.

Final tip: Several states publish Frequently Asked Questions regarding medical direction, says **Kelly Dennis, MBA, ACS-AN, CANPC, CHCA, CPC, CPC-I,** owner of Perfect Office Solutions in Leesburg, Fla. One of the earliest to do this was Palmetto GBA, whose website you can search for information.

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