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Part B Insider (Multispecialty) Coding Alert

The Patient Is Sedated, the Surgeon Calls It Quits: What Should You Bill?

Can you bill for anesthetic when the procedure didn't actually happen?

An anesthetist's time is valuable too, but often her reimbursement will depend on whether the surgeon was able to go through with a procedure.

Some coders say it's definitely possible to bill for aborted anesthetic procedures. "We've done pretty well," says **Barbara Johnson** with Loma Linda University Anesthesiology Medical Group in Loma Linda, Calif. "We generally get paid immediately." Also, **Patrick Cafferty**, president and CEO of Neurosurgical Associates of Western Kentucky, says he's had no trouble getting paid for these services.

But others say they don't even try to bill for anesthetic for canceled procedures. "From a PR standpoint and what I feel to be a true positive business standpoint, we don't bill for those procedures," says **Lee Broadston**, president and CEO of BCS in Waconia, Minn.

"If the anesthesia provider bills for it, and the surgeon doesn't bill for [the surgery], that's almost a no-win situation because most payers won't recognize an anesthesia without a surgeon," Broadston adds. You end up chasing a $200 payment that you'll never receive. And even if you get paid, you may hear complaints from a patient who scrutinizes her explanation of benefits forms obsessively.

It's important to remember that normal anesthesia administration doesn't end until the patient is "through emergent and wakes up again," Broadston says. Whether you can bill may depend on when - and why - the procedure was scratched, he says:

Before induction. The anesthesiologist might also decide after meeting with the patient not to go ahead with the anesthesia for some reason. Or the procedure may be cancelled after the patient is prepped but before induction.

In that case, you can bill for that face-to-face visit as a consult using **CPT 99251** -**99255** , Broadston says. But don't expect Medicare to reimburse an anesthesiologist for a consultation very easily. You can also bill using an evaluation and management code, also with slim chances.

It's probably better to bill for an inpatient or outpatient E/M visit as opposed to a consult, says **Barbara Johnson** with Loma Linda University Anesthesiology Medical Group in Loma Linda, Calif. "It's hard to say that just because we were scheduled for surgery, they requested a consult."

Within 15 minutes after induction. Quite often, a case is canceled due to equipment failure or because someone else didn't prep the patient, Broadston says. Those cancellations generally happen within 15 minutes of the start of anesthesia time, so it's probably not worthwhile to bill for them. "The effort is just so significant compared to the remote possibility you're going to get paid anything."

But Johnson says you can often bill for anesthesia that stops soon after induction. (See story, page 181).

First half-hour of anesthesia. Sometimes a procedure is canceled after anesthesia starts, because of medical complications. The patient's cardiac output or blood pressure may be abnormal, or some other vital sign may persuade the anesthesiologist to abort. In those cases, chances are the patient was under anesthetic for only 15 to 20 minutes.

If you code for those cases, you'll want to use a modifier that shows a reduced level of service, Broadston says. Along with that reduced service, you'll want to submit lots of documentation and records.

Longer delays. The surgeon might decide 35, 45 or 50 minutes into the procedure that the procedure isn't going right and he has to cancel. At this point, the anesthesiologist has basically done his job, so if you're billing for time it may be possible to receive almost your full payment. But Broadston says it may still be challenging to get paid.