50 SHADES OF GREY:
OIG AUDITS OF ACADEMIC
ANESTHESIA DEPARTMENTS

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DISCLOSURES

• I serve as a health care economic consultant to a variety of entities including: physician practices, hospitals, health systems, universities, states and the US government.

• I am a major stockholder in my company, Stead Health Group, Inc.

• This presentation does not contain information or services for which I could derive a financial benefit.
OVERVIEW

- Review the Medicare regulations regarding anesthesia and pain medicine
- Understand the how the HHS OIG is reviewing your claims and using the false claims act
- Strategies for meeting both clinical and documentation needs
- Legal protections afforded state institutions from the False Claims Act
- Establishing a defensive strategy to minimize exposure

THERE’S MONEY IN ENFORCEMENT!

- ROI of 17 to 1
- OIG recovers $17 for each $1 invested in enforcement activities

THERE’S MONEY IN ENFORCEMENT!

• False Claims Recoveries:
  • $3 billion/yr (FY 2011) ($8.7B since 2009)
  • Whistleblowers accounted for $2.8B
  • “[H]ealth care accounted for the lion’s share … $2.4 billion (80%)”

FALSE CLAIMS ACT

• The False Claims Act (FCA) (31 U.S.C. §§3729-3733) is a federal statute that imposes penalties on entities that improperly bill the government. In the health care arena, this means knowingly submitting false claims to the Medicare or Medicaid programs for reimbursement.

• Examples of false claims include:
  • Upcoding
  • Misrepresenting the services that were rendered
  • Submitting claims for services that were not performed
  • Unbundling
  • Submitting claims for unreasonable costs.
FALSE CLAIMS ACT

• In order to encourage individuals with the knowledge of wrongdoing to come forward, the FCA allows those individuals, called “relators,” to file a civil suit, a qui tam action, against the wrongdoer in the name of the government. See 31 U.S.C. §3730(b). In return for reporting the wrongdoing and for being a party to the suit, the relator receives between 15% and 30% of the award. 31 U.S.C. §3730(d)(1)&(2).

• Unfortunately, this monetary incentive, which often equals millions of dollars, could give rise to abuse and may result in claims that are aptly termed “parasitic.”

FALSE CLAIM ACT MAY NOT BE APPLICABLE TO STATE INSTITUTIONS

• State agencies are not “persons” subject to FCA liability
• The University is a state agency and thus not a “person,” and therefore may not be sued under the FCA
• The “University Associates” are typically business units of the states
• The “defendants” are therefore not “persons” and may not be sued under the FCA
• The University will vigorously contest the applicability of the FCA and potential FCA liability in this case
REVIEW OF THE GOVERNMENT AUDIT PROTOCOL

- Audit period: Typically selected over a period of years
- Dates of service selected via multiple criteria
  - Judgmentally selected by OAS
  - Selected based on relator documents by DOJ
- Dates of service actually audited may be arbitrary
- Request for all relevant records - open ended

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MEDICARE PAYMENTS FOR ANESTHESIA SERVICES

- Statutory
  - OBRA 1990, (Pub. L. 101-508)
- Regulatory
  - Medicare - Medicare Carrier Manual, Chapter 12
    - Sections 50 (Payment), 100 (Teaching), 140 (CRNA Payment)
  - Medicaid - guided by state
COMPLIANCE RISK

Federal government has been funding increased enforcement efforts, believing that recoveries through settlements and prosecutions are an important way to combat and deter improper billing.

- Incentive for whistleblowers “qui tam” 15-30% of proceeds (or settlement)
- Automatic Office Inspector General (OIG) Investigations - criminal investigations on a phone call from an employee (former or current)
- MACs are using computer screens and post-payment audits

BILLING COMPLIANCE: AVOIDING “FRAUD & ABUSE”

- Billing Requirements and Billing Compliance

“I will not encounter billing compliance problems so long as you provide good patient care and are not out to cheat the system.”

WRONG!

You do not need to intend to cheat the system to incur substantial financial liability for bills you (or others) submit for your services, especially if the patient was a Medicare, Medicaid or other federal program beneficiary.
WHAT IS THE RISK?

- False Claims: triple damages + $11,000 per claim
- Improper submitted claim for $450: $12,350 ($11,000+3*$450)

The government does not have to establish specific intent to defraud and it is no defense that the Group provided other reimbursable services or that it did not have actual knowledge that the claims were false.

CRIMINAL FALSE CLAIMS LAWS

- Prohibit knowingly & willfully making false statement in claim to gov’t, or
- Submitting false & fictitious claims
  - Knowledge of falsity not required
  - “Willful blindness”/deliberate ignorance sufficient for liability
CALCULATING TIME

• Continuous, actual presence
• Starts: when begin to prepare patient for anesthesia
  • Pre-op exam time is not anesthesia time
  • When does time start when doing other, separately paid services?
    • Post-op pain epidural
• Ends: when patient may be safely transferred for post-op care
• If presence of “Qualified Individual” ceases, use discontinuous time.
• NEVER ROUND TO THE NEAREST FIVE MINUTES

TIME

• Medicare/Medicaid: Report Actual Time - without approximation
  • Payment Rounded to nearest tenth of hour
• Private payors
  • Varies
  • Managed care contract may address
• But new standardization of forms may lead to all payors using actual time
  • Time in minutes is now reported via X12 5010 instead of time units
DOCUMENTING TIME FOR ANCILLARY PROCEDURES

• Document time of preop block (or line placement)
  • Document: start & stop of preop block time
    • Separate from anesthesia time
    • If not documented, OAS assumes fraud
  • No need to deduct time if lines placed intraoperatively

QUALIFIED PROVIDERS & TIME

• Time stops if “qualified individual” not w/patient
• “Qualified individual” who can be medically directed:
  • AAs & CRNAs (& student NAs)
  • Residents, interns
• Not a “Qualified individual”
  • Medical student
  • Holding area/circulating nurse
DISCONTINUOUS TIME

- Can aggregate discontinuous segments of anesthesia time
  - E.g., delays in starting surgery; regional cases
- Anesthesia time & monitoring w/in each block of time must be continuous
- Must document start & end times of any separate segments of anesthesia time
- Consider impact of discontinuous time on
  - Concurrencies – number of cases being “medically directed”
  - Residents and CRNAs
    - Do they appear as working on more than one case at the same time?

FREQUENCY DISTRIBUTION OF MINUTES

Evidence of Rounding to 5 minute interval on End Time
MEDICAL DIRECTION WITH RESIDENTS AND NURSE ANESTHETISTS

It is our intent to use the example in section 15018C to illustrate the policy and not to limit the policy only to pre or post anesthesia care. Under the principle in this section, we would allow another member of the group to substitute for the performing physician during the intraoperative period. Of course, we would allow this policy only if all members of the group have appropriately reassigned their benefits to the group and the medical record documents the performance of the various activities by the different members of the group. It would be appropriate for the group to submit the claim in the name of the anesthesiologist who spent the largest amount of time with the case.

Letter from Terry Kay, Nov 25, 1997
MEDICAL DIRECTION AND TEACHING

- When Medical Direction is performed by more than one physician, each Teaching Physician must personally document his or her presence during specific services and the specific services he or she performed. Additionally, both must personally document their immediate availability during the portion of the case during which they provided medical direction. The documentation must clearly show when the transfer occurred and that all the elements of medical direction were met and by which anesthesiologist.

- When more than one anesthesiologist is involved in a medically directed case, the charge is submitted under the name of the anesthesiologist who spent the most time on the case. When cases are billed under the Anesthesia Teaching Physician rules, they are billed under the name of the anesthesiologist who started the case.

MEDICAL DIRECTION (CONT.)

- Physician must participate only in the most demanding procedures of the anesthesia plan, including, if applicable, induction and emergence.

- Physician must document in the medical record that he or she performed:
  - the pre-anesthetic examination and evaluation
  - provided indicated post-anesthesia care
  - were present during some portion of the anesthesia monitoring
  - were present during the most demanding procedures, including induction and emergence, where indicated.
MEDICAL DIRECTION (CONT.)

- Physician can medically direct two, three, or four concurrent procedures involving qualified individuals, all of whom could be CRNAs, AAs, interns, residents or combinations of these individuals.
- For services furnished on or after January 1, 2010, the medical direction rules do not apply to a single resident case that is concurrent to another anesthesia case paid under the medical direction rules or to two concurrent anesthesia cases involving residents.

*MCM, Ch 12, Section 50C*

MEDICAL DIRECTION (CONT.)

- If anesthesiologists are in a group practice, one physician member may provide the pre-anesthesia examination and evaluation while another fulfills the other criteria. Similarly, one physician member of the group may provide post-anesthesia care while another member of the group furnishes the other component parts of the anesthesia service.
- However, the medical record must indicate that the services were furnished by physicians and identify the physicians who furnished them.

*MCM, Ch 12, Section 50C*
However, if the physician leaves the immediate area of the operating suite for other than short durations or devotes extensive time to an emergency case or is otherwise not available to respond to the immediate needs of the surgical patients, the physician’s services to the surgical patients are supervisory in nature. Carriers may not make payment under the fee schedule.

**MEDICAL DIRECTION (CONT).**

**RESIDENTS AND NURSE ANESTHETISTS**

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>DESCRIPTION OF SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Performance</td>
<td>Anesthesiologist performs case alone, oversees one OR at a time</td>
</tr>
<tr>
<td>Medical Direction</td>
<td>Anesthesiologist directs up to four ORs simultaneously. Must perform all seven steps</td>
</tr>
<tr>
<td>Medical Supervision</td>
<td>Anesthesiologist supervises more than four ORs simultaneously</td>
</tr>
<tr>
<td>CRNA (Without Supervision)</td>
<td>CRNA performs case without anesthesiologist present</td>
</tr>
</tbody>
</table>
# RESIDENTS AND NURSE ANESTHETISTS

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>PAYMENT TO PHYSICIAN</th>
<th>PAYMENT TO CRNA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Performance</td>
<td>Anesthesiologist receives 100% of payment</td>
<td>No CRNA payment received</td>
</tr>
<tr>
<td>Medical Direction</td>
<td>• Anesthesiologist receives 50% of payment</td>
<td>• CRNA receives 50% of payment</td>
</tr>
<tr>
<td></td>
<td>• If anesthesiologist fails to performs 7 steps, 3 units for preop and 1 unit for presence at</td>
<td>• Where CRNA employed by hospital, hospital receives 50% of payment</td>
</tr>
<tr>
<td>Medical Supervision</td>
<td>Anesthesiologist receives 3 units for preop and 1 unit for presence at induction</td>
<td>• CRNA receives 50% of payment</td>
</tr>
<tr>
<td></td>
<td>• CRNA receives 50% of payment</td>
<td>• Where CRNA employed by hospital, hospital receives 50% of payment</td>
</tr>
<tr>
<td>CRNA Without Supervision</td>
<td>No Payment to Anesthesiologist</td>
<td>• CRNA receives 100% of payment</td>
</tr>
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<td></td>
<td>• If employed by hospital, hospital receives 100% of payment</td>
<td></td>
</tr>
</tbody>
</table>

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# MEDICAL SUPERVISION

- The Part B Contractor may allow only three base units per procedure when the anesthesiologist is involved in furnishing more than four procedures concurrently or is performing other services while directing the concurrent procedures. An additional time unit may be recognized if the physician can document he or she was present at induction.

*MCM, Ch 12, Section 50C*
Failed Medical Direction occurs when any portion of the Medicare rules of Medical Direction is not provided or documented or when a non-allowed activity is performed during medical direction.

- If a Certified Registered Nurse Anesthetist (CRNA) is involved in a failed medical direction case, STATE LAW MAY permit billing under a CRNA’s name with the –QZ modifier and payment at 100% allowable.
- No anesthesiologists fees should be billed for failed medical direction cases.

7 STEPS AND 6 EXCEPTIONS

1. Perform preanesthetic exam
2. Prescribe anesthetic plan
3. Personally participate in most demanding parts of the procedure
4. Ensure performance by qualified anesthetist
5. Monitor at frequent intervals
6. Remain physically present/available for immediate diagnosis
7. Provide indicated post-anesthetic care

1. Addressing an emergency of short duration in the immediate area
2. Administering a labor epidural
3. Periodic (not continuous) monitoring of an obstetric patient
4. Receiving patients entering the operating suite for the next surgery
5. Checking or discharging patients in the recovery room

Exceptions
MEDICAL DIRECTION RISKS

• Why is medical direction a risk area?
  • Rules are detailed and specific
  • Not always intuitive
  • Must document all 7 steps
    • Lack of documentation can lead to inability to explain what services actually were provided
• Biggest areas of risk:
  • Not meeting all seven steps of medical direction
  • Performing activities not listed in the six exceptions

IMMEDIATELY AVAILABLE

➢ Concept of “immediately available may seem obvious, but specifics are undefined
➢ “Physically present and available for immediate diagnosis and treatment of emergencies” 42 C.F.R. 415.110
➢ No specifics about proximity
➢ “The CMS is not defining availability in terms of geographic location vis-à-vis the operating room” Claims Processing Manual, Ch. 12, Section 100.1.2(A)(Surgery)
➢ 2011 OPPS Final Rule- “physically present…but without reference to any physical boundary.”
IMMEDIATELY AVAILABLE

- No clear guidance from CMS
- Expert opinion of anesthesiologist with years of experience in medically directing and medically supervising anesthesia services:
  - If anesthesiologist can move between locations within the same operating room suite, he/she is usually deemed to be “immediately available” to address any emergency.

IMMEDIATELY AVAILABLE

- Anesthetizing locations
  - Main OR suite, Labor & delivery
  - Other areas -- e.g., MRI, EP, ambulatory surgery
- Must remain physically present & immediately available
- Even for permitted exceptions
IMMEDIATELY AVAILABLE AMBIGUITIES

• Additional areas to be defined:
  • When does emergence occur?
    • A process, not a single point
  • How frequently must you monitor cases for “frequent” monitoring?
    • Single time frame won’t apply to all cases
  • How what locations are considered physically present: time and distance

MEDICAL DIRECTION AMBIGUITIES

• What is “short” duration?
  • Need for common definition
  • “Receiving” patients for next surgery
    • Doesn’t permit preanesthetic exam (unless CRNA w/you)
  • How far away can you be and still be immediately available?
    • Again, need common definition
MEDICAL DIRECTION: OTHER SERVICES

• Example of services that cannot be personally performed while medically directing:
  • Pain blocks
  • Easy target for investigators & RACs: Are medically directing physicians doing pain blocks?

RULES APPLY TO EXCEPTIONS

• Even if carrier says you can do other things, you still must meet medical direction requirements:
  • Participate in most demanding portions
  • Monitor at frequent intervals
  • Must remain immediately available
• Can’t routinely rely on exceptions
  • “We do not expect that a physician who is directing the administration of anesthesia to four surgical patients would be involved routinely in furnishing any additional services to other patients. . . .
  • Carriers will review hospital records to ensure that such circumstances do not occur frequently [and] are of short duration . . . .”
BREAKS FOR COLLEAGUES

- Medically directing physician cannot provide a "break" for a CRNA
  - Would be personal performance
  - Can't medically direct & personally perform at the same time
  - Have "like" provider relieve "like". (eg CRNA relieves CRNA, Resident relieves Resident)

INTRAOPERATIVE HANDOFF

- Billing risk: failure to document
- Change in medically directing physician AND
  - The time of the handoff
- Change in CRNA, Resident or AA
- Change in "type" CRNA -> Resident
INTRAOPERATIVE “HAND-OFFS”

- Medicare -- Medically Directed procedure
  - Anesthesiologists within a group practice may substitute for each other
- Medical record must identify who provided which services
  - Bill in name of physician with most time on case
  - Teaching Rule: Bill in name of physician who started the case

HANDOFF DOCUMENTATION

- Consider developing a standard template for handoffs
  - AHRQ - MATCH (Managing at Transitions and Clinical Handoffs)
  - ACS - Standards for Surgical Handoffs
Concurrency is defined with regard to the maximum number of procedures that the physician is medically directing within the context of a single procedure and whether these other procedures overlap each other.

Concurrency is not dependent on each of the cases involving a Medicare patient. For example, if an anesthesiologist directs three concurrent procedures, two of which involve non-Medicare patients and the remaining a Medicare patient, this represents three concurrent cases.

CONCURRENCE EXAMPLES

- **Room 1**
  - Turnover: Case
  - Turnover: Case
  - Personally Performed or 1:1

- **Room 1**
  - Turnover: Case

- **Room 4**
  - Turnover: Case
  - Medical Direction 1:2

- **Room 3**
  - Case
  - Case
  - Case

- **Room 8**
  - Case
  - Case
  - Medical Direction 1:3 & 1:2

- **Room 9**
  - Case
  - Case
CALCULATING CONCURRENCIES

• Time measured in minutes
  • Overlap of one minute = concurrency
  • Personally performed case, resident or CRNA services:
    • No overlapping times
  • Medically directed case: Up to 4 concurrent cases permitted
• In case of intraoperative handoff, must calculate concurrences for each medically directing anesthesiologist
  • Cannot use concurrences for only one of the anesthesiologists
    • E.g., the one with the most time on the case
CONCURRENCY MAPS FOR EACH DAY

STRATEGIES: MULTIPLE RESPONSIBILITIES

- Don't personally perform if medically directing
  - Hand off cases to a colleague
- Watch if Case 2 starts during Case 1
  - CRNAs can't be in 2 cases at once
- Don't shave time for back-to-back cases
  - Appearance of manufactured, not actual, time
  - Inconsistency with hospital times?
STRATEGIES: MULTIPLE RESPONSIBILITIES

- Don’t personally perform if medically directing
  - Hand off cases to a colleague
- Watch if Case 2 starts during Case 1
  - CRNAs can’t be in 2 cases at once
- Don’t shave time for back-to-back cases
  - Appearance of manufactured, not actual, time
  - Inconsistency with hospital times?

PERSONAL PERFORMANCE

Anesthesiologist performs case alone, OR oversee one Operating Room at a time
PERSONAL PERFORMANCE

• If personally performing, anesthesiologist is fully occupied
  • Cannot have responsibility for other cases
    • E.g., labor epidural
  • Cannot leave room
    • E.g., present during bypass
• If personally performing: Can’t bill for more than one patient at a time
  • Cannot be in “continuous actual presence” for more than one patient at a time

MEDICAL NECESSITY

• Medicare (& other payors) only pay for services that are medically necessary
  • Problem areas:
    • MAC
    • Anesthesia for GI procedures
    • Anesthesia for EP procedures
    • Anesthesia for Pain procedures
    • Multiple post-op Pain procedures
WHAT IS DOCUMENTATION?

• Manual (handwritten) (if no EMR) indications of:
  • Presence & services provided
  • CMS view: If the service isn’t documented, it wasn’t provided
  • Check-offs & initials not sufficient
    • Don’t show service provided
    • Can’t disprove testimony to contrary
MAJOR RISK AREA

- Patient’s record must show
  - What Services provided
  - Who provided them
    - To document care provided
    - To justify coding of the service
    - To support claim for payment
  - When they were provided

COMMON DOCUMENTATION ERRORS

- Inadequate documentation of:
  - Time
  - Medical direction
  - Intraoperative handoffs
  - Precise procedure performed
  - Insertion of invasive monitoring lines
  - Monitoring of labor epidurals
DOCUMENTATION

- Avoid Global Statements such as: “I personally participated in induction, emergence, and key portions of the anesthetic and remained immediately available throughout.
- Itemized compliance statements:
  - “Participated in induction” -- signature
  - “Participated in emergence” -- signature
  - “Participated in key portions (identify) -- signature
- It is best to have individualized style in documenting services

DOCUMENTING LABOR EPIDURALS

- Documentation:
  - What services provided?
  - Who provided them?
  - Times of monitoring?
  - Who
    - Performed the preop?
    - Inserted the epidural?
    - Monitored?
    - Removed catheter?
  - When did monitoring occur? For how long?
POST-OP PAIN DOCUMENTATION

• Surgeon’s request
  • Preferably, have surgeon document
• Epidural/block primarily for post-op pain
  • Anesthesia for surgical procedure not dependent upon efficacy of regional technique
• Time for pain service not included in anesthesia time

RECENT OAS/OIG AUDITS

• Spanned 6-10 Years
• Based upon a sample of 20 days within those 10 years
• < 400 Medicare and Medicaid services
• Inexperienced OAS team (no anesthesia experience)
• Non-random sample (relator driven)
OAS/OIG CLAIMS ANALYSIS

Analysis of Medicare Claims and Error Rates/Dollars

<table>
<thead>
<tr>
<th>Error Type</th>
<th>Description</th>
<th>Monetary Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>&quot;AA&quot; modifier used instead of &quot;QK&quot; modifier.</td>
<td>50% allowed</td>
</tr>
<tr>
<td>2</td>
<td>Overlapping surgeries in different buildings.</td>
<td>Unallowable</td>
</tr>
<tr>
<td>3</td>
<td>Overlapping surgeries in same building, different floor.</td>
<td>Unallowable</td>
</tr>
<tr>
<td>4</td>
<td>Overlapping surgeries in same operating suite.</td>
<td>Unallowable</td>
</tr>
<tr>
<td>5</td>
<td>Miscellaneous: No post-op record, missing initials, etc.</td>
<td>Unallowable</td>
</tr>
</tbody>
</table>

OAS/OIG SAMPLING METHODS

- Nonprobability Sampling
- Judgmental Sampling - sample based on who they think would be appropriate to study. Introduces self-selection bias, making it unlikely that the sample will accurately represent the broader population.
- Validity of the estimates of the parameters is unknown.
CRITICAL DATA

- Patient Identification
  - MRN, Name
- Case
  - Procedure, Anesthesia Start and Stop Times
  - Providers: attending, resident, nurse anesthetist
  - Type of Anesthesia, Room number
  - Factors effecting Medical Direction/Supervision
- Claim
  - CPT, Providers, Time, Modifiers, Units billed

SOURCE DOCUMENTS

- OR LOG
- CMS 1500 Form(s) or alternately Account Detail Data
- Remittance Information
- Operating Room Record
- Anesthesia Pre-Anesthetic Assessment
- Anesthesia Record
  - Post Anesthesia Care Unit
  - PACU Admission Orders
- Operative Report
- Interdisciplinary Notes
ANESTHESIA PRE/POST OP (LOWER)

POST ANESTHESIA ASSESSMENT

POST OP NOTES – PACU ORDERS

b). May assist respiration with Ambu bag PRN.

13. If patient is intubated, maintain ventilation as:

14. When vital signs are stable, may give the following:
   - NS 100 cc's
   - 1 mg IV PRN pain
   - 1 mg IV PRN nausea

15. Discharge to ward 30 minutes after last narcotic, narcotic antagonist, vasoactive medication and/or neuromuscular blocking agent antagonist.


17. LAB: □ Blood Sugar  □ H/H  □ ABG’s  □ Other:

18. OTHER:

Tighe 2:00 p.m. 8 (X-ma’s agent) and pain

DATE:  1/31/14  TIME:  7:03  P.M.  MD:  _______

NOT POSTOP DOCUMENTATION
<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/1/13 09:00</td>
<td>Anu post q x</td>
<td>TED B2 supcrf acy on a lft side. No f ache swelling a mid and given pri s due to the t. L rly recall phys red. F ac revealed significant swelling to face difficult to e eye ope. An o ordered a labord tenden to adv 85, 54.</td>
</tr>
</tbody>
</table>
Case information extracted for each case

Daily list of providers, rooms

Time Mapping of all cases 3 ways:
- Case by Anesthesiologist and Room
- Case by 2nd Provider and Room
- Case by Room and 2nd Provider

Verification of room number, times and providers

Concurrency mapping each case to determine appropriate modifier
AUDIT REVIEW CHALLENGES

- Missing components of patient record
- Poorly imaged copies
- Paper-based records with legibility issues
- Contradictory information
- Providers with very similar or same names (e.g., RES Yeh, RES Yuh,)
- Same numbering system for rooms across multiple locations (LR 3, L&D 3, OSS3, Rm 3)
- Academic Anesthesia is a GROUP PRACTICE. Anesthesia attending physicians cover for each other.

OAS MEDICARE REVIEW
10/10/03
States that there are case “Overlaps”
Found an overall 70% error rate
CONCURRENCY: ANESTHESIOLOGIST AND ROOM

- NO OVERLAPS
- 1:2 UNTIL 14:50
- Case 1812266 in OSS #2
  - OR record says OSS #2, Anes record OSS #3; Attending N relieved Attending B at 1530
- Case in 1735668 in OSS #3
  - Started by Attending G, relieved by Attending B after 15:30, who provided the majority of the care, and therefore case was billed in his name.

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CASE 1735668

Started by GXXXX

Assumed by BXXXXX

No Handoff documentation

Poor Documentation on Steps of Medical Direction

Attending and Times in Conflict with Nursing Notes

CASE 1735668 – STARTED BY G
CASE 1735668 – PACU NOTE, COMPLETED BY BXXX

NOT A POST OPERATIVE VISIT

AUDIT TAKEAWAYS: ENFORCEMENT FOCUS

- Medical Direction - need to document ALL SEVEN STEPS
  - Time: Start/Stop/Handoff times
    - Everyone is tracked: Attendings, Residents and CRNAs
  - Immediately available - physically present
  - Handoffs and Breaks
  - Post Operative Visit
- Overlaps: Pain blocks and anesthetic administration overlaps
- Documentation - poor documentation resulted in high error rate
  - Extensive “forensic” chart review reduced error rate to < 5%.
CONCLUSIONS

• Develop an anesthesia-specific compliance plan addressing:
  • Documentation by clinicians (and who is responsible)
  • Time (and which times are to be used: Nursing/Anesthesia)
  • Handoffs
  • Permissible activities during Medical Direction
  • Immediately available (distance and time)
  • Plan for an audit to happen
• Conduct a “gap” analysis of your vulnerabilities
• Conduct a practice audit under a “privileged and confidential” protection and act upon it

Thank You

Stan.Stead@Stead-Group.com
PREANESTHESIA

<table>
<thead>
<tr>
<th>PRE-ANESTHESIA EVALUATION</th>
<th>TJC</th>
<th>CMS</th>
<th>ASA</th>
<th>SHG</th>
<th>BILL</th>
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<tbody>
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<td>Patient Name, Gender, DOB (Identity Confirmed)</td>
<td>X</td>
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<td>X</td>
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<td></td>
</tr>
<tr>
<td>Surgeon Name</td>
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<td>X</td>
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<tr>
<td>Date and Time</td>
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INTRAOPERATIVE

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### PREANESTHESIA

**PRE-ANESTHESIA EVALUATION**

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- Patient Name, Gender, DOB (Identity Confirmed) | X | X | X | X |
- Surgeon Name | X |
- Date and Time | X | X | X | X |
- Diagnosis | X | X | X | X |
- Proposed Procedure and Site (side) | X | X | X | X |
- Pertinent History | X | X | X | X |
- Pertinent Physical | X | X | X | X |
- Airway Exam | X |
- Pertinent Family History - Disease or Anesthetic Complication | X | X | X | X |
- ROS - including obstructive sleep apnea | X | X |
- Anesthetic History | X | X | X | X |
- Medication | X | X | X | X |
- Allergies | X | X | X | X |
- Vital Signs | X | X | X | X |
- Height and Weight | X |
- Review Objective Diagnostic Data (Labs, ECG, Xray, etc.) | X |
- Assignment of Physical Status (PT-P6, E) | X | X | X | X |
- Prescription of Anesthetic Plan and Premedication | X | X | X | X |
- Anesthetic Risk, Complications discussed and Patient Consent | X | X | X | X |
- Anesthesiologist printed name and Signature | X | X | X | X |

### INTRAOPERATIVE

**INTRAOPERATIVE DOCUMENTATION**

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- Patient Name, Gender, DOB (Identity Confirmed) | X | X | X | X |
- Surgical Procedure(s) | X | X | X | X |
- Surgeon Name and assistants | X | X |
- Preoperative and Postoperative Diagnoses | X | X | X | X |
- Anesthesia Start Date and Time | X | X | X | X |
- Anesthesia Stop Date and Time | X | X | X | X |
- Surgery Start, Surgery Stop | X | X |
- Preop Antibiotic ordered, time administration was complete | X |
- NPO status | X |
- "Time Out" before procedure | X | X |
- Thermal regulation | X |
- Patient Position, Positioning and padding | X | X | X | X |
- Location (OR #) | X |
- Anesthesia Machine, Ventilator, Equipment Check Performed | X | X |
- Monitors(oxygenation, ventilation, ECG, circulation, NMB, temp) | X | X | X | X |
- Preinduction Patient Assessment (Change from Preop) | X | X | X | X |
- Premedication | X | X | X |
- Allergies | X | X | X | X |
- Airway mgmt. (blade, ET, LMA) | X |
- Invasive Monitors (Aline,CVP,PA) start/stopp times, indication, sterility | X | X | X | X |
- Additional monitors (TEE, EEG, Doppler) | X | X |
- Continuous Monitoring throughout procedure | X | X |
- Anesthesia Technique(s) or Type(s) | X | X | X | X |
- Vital Signs recorded every five minutes | X | X | X | X |
- Medications Administered | X | X | X | X |
- Time, Types and Amts of IVs, blood & O(urate, blood loss) | X | X | X | X |
- Blocks performed (times, type, technique, indication, sterility) | X | X |
- Key events (induction, time out, incision, closure, extubation) | X | X | X | X |
- Standard abbreviations, if used | X | X |
- Controlled substance disposition | X |
- Time or periods of time of Transfer of Care (if occurs) | X | X | X | X |
- Anesthesiologist printed name and signature | X | X | X | X |
## Recovery Room Documentation

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## Post Anesthesia Documentation

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# Pre Anesthesia Evaluation Requirements

Date __________  Time __________

Pre-anesthesia Information:
- Pre-anesthesia data collection according to institutional practice
- Medical History, including anesthesia, drug and allergy history
- Physical Findings

Vital signs reviewed: Yes
Medical history reviewed: Yes
Laboratory, imaging and consultations reviewed: Yes
Patient interviewed and examined: Yes

Potential physical findings noted:

ASA Physical Status: __________

Anesthesia Plan

Additional Comments

Evaluator Signature: __________  MD __________  ORNA __________  AA __________  Clinician ID

Note: Designed only for CMS compliance/participation; additional elements may be required by local, state or federal rules or regulations.
**POST ANESTHESIA EVALUATION FORM**

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- Vital signs in patient’s normal range: Yes __
- Respiratory function stable; airway patent: Yes __
- Cardiovascular function and hydration status stable: Yes __
- Mental status recovered: patient participates in evaluation: Yes __
- Pain control satisfactory: Yes __
- Nausea and vomiting control satisfactory: Yes __

**Comments**

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Evaluator Signature: MD ___ CRNA ___ AA ___
Clinician ID: __________

Note: Designed only for CMS compliance/participation; additional elements may be required by local, state or federal rules or regulations.