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2019 Relative Value Guide Updates Include Anesthesia Time and Field Avoidance

While there were no changes to the CPT® codes that describe anesthesia care for 2019, ASA members and their practices need to know that the 2019 edition of the Relative Value Guide® (RVG™) includes changes on how the RVG defines anesthesia time and how it addresses field avoidance. This Timely Topic provides relevant information and background for these revisions.

Definition of Anesthesia Time

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2018 RVG: *Anesthesia time begins when the anesthesiologist begins to prepare the patient for anesthesia care in the operating room or in an equivalent area, and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient is safely placed under post-anesthesia supervision.*

2019 RVG: *Anesthesia time is defined as the period during which an anesthesia practitioner is present with the patient. It starts when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the patient, that is, when the patient is safely placed under postoperative care. Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service. In counting anesthesia time for services furnished, the anesthesia practitioner can add blocks of time around an interruption in anesthesia time as long as the anesthesia practitioner is furnishing continuous anesthesia care within the time periods around the interruption.*

Payments for anesthesia services are determined by totaling base units, time units, and modifying units and multiplying that sum by a conversion factor. Base units and modifying units submitted for payment have defined unit values and the conversion factor is established by the Centers for Medicare & Medicaid Services (CMS) for Medicare claims and by contract for claims submitted to private payers. However, total anesthesia time has inherent variability since it is dependent on each unique surgical episode. It is important that we as physician anesthesiologists are vigilant in accurately reporting anesthesia time to avoid overbilling and costly audits. In addition, just as crucial, is the prevention of underbilling resulting in lost revenue to the detriment of anesthesiologists and their practices.

When reporting time on claims, CMS and many private payers allow for reporting of discontinuous time. As stated in the 11/2/1999 Federal Register, *“Anesthesiologists and CRNAs should report the total anesthesia time on the HCFA claim form as the sum of the continuous anesthesia block times. The medical record should be documented so that a medical record auditor can see the continuous and discontinuous periods and that the reported total anesthesia time sums to the blocks of continuous time.”*

The definition of anesthesia time as it previously appeared within the RVG did not specifically address the concept of discontinuous time. The revised definition is intended to educate and ensure that all anesthesiologists and their respective anesthesiology practices are aware of this option and how to properly and compliantly make use of it.

Discontinuous periods occur when there is an interruption in anesthesia services and the anesthesiologist is temporarily not in attendance for direct monitoring and care of the patient, despite not having

completed the surgical procedure. One example of discontinuous time (per the proposed rule in the 7/22/1999 Federal Register) could be when anesthesia is provided via a regional or block technique and the patient may be safely observed by a non-anesthesia professional between the time the block is administered and the start of the surgical intervention.

This interrupted time, between the continuous anesthesia time should not be billed. The bundling of discontinuous time, either before or after the interruption, is allowed by CMS as acceptable billing.

It is important to note that discontinuous time is NOT to be used while the surgical procedure is underway. Standard I in the [ASA Standards for Basic Anesthetic Monitoring](#) states that “Qualified anesthesia personnel shall be present in the room throughout the conduct of all general anesthetics, regional anesthetics and monitored anesthesia care.”

The revised RVG definition is consistent with the CMS definition for anesthesia time from the Medicare Claims Processing Manual, Chapter 12, Section 50G which as of 11/28/2018 states that “Anesthesia time is defined as the period during which an anesthesia practitioner is present with the patient. It starts when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ends when the anesthesia practitioner is no longer furnishing anesthesia services to the patient, that is, when the patient may be placed safely under postoperative care. Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service. In counting anesthesia time for services furnished, the anesthesia practitioner can add blocks of time around an interruption in anesthesia time as long as the anesthesia practitioner is furnishing continuous anesthesia care within the time periods around the interruption.”

Please note the RVG deviates from the CMS text in that the RVG states that time ends when the patient is safely placed under postoperative care. The CMS text states that time ends when the patient may be placed safely under postoperative care. This distinction between “is safely placed” and “may be placed safely” first appeared in the 2007 edition of the RVG to address PACU back-ups when the patient could be safely transferred, but the anesthesiologist had to stay with the patient and provide postoperative care because the PACU could not accept the patient.

Special note on time spent on certain separately billable procedures such as nerve blocks for acute postoperative pain control or placement of invasive monitoring lines: If the procedure is performed before induction of anesthesia or performed after emergence, procedural time should not be included in the total anesthesia time, despite the administration of sedation or the continuous use of pre or postoperative monitoring.

Field Avoidance

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2018 RVG: *Any procedure around the head, neck, or shoulder girdle, requiring field avoidance, or any procedure requiring a position other than supine or lithotomy, has a minimum Base Value of 5 regardless of any lesser base value assigned to such procedure in the body of the Relative Value Guide.*

2019 RVG: *Whenever access to the airway is limited (eg, field avoidance), the anesthesia work required may be substantially greater compared to the typical patient. This anesthesia care has a minimum base unit value of 5 regardless of any lesser base unit valued assigned to such procedure in the body of the Relative Value Guide. Refer to the text in Modifier 22, page xvi.*

Prior to the 2019 edition, the RVG guidance pertained to field avoidance and positioning. The 2019 guidance is more specific to field avoidance as the resulting issues with airway access are the main reasons for the additional work and risk that trigger the increased unit(s). Further, there are now

anesthesia services for procedures that are typically performed laterally that have base unit values below five. These base unit values represent the values that our surveys supported.

The RVG guidance now provides information on how to convey the request for additional units via the use of Modifier 22 – Increased Procedural Services. Instructions associated with modifier 22 provide guidance on the necessary documentation elements that should be conveyed to payers when submitting such claims.

The ASA Relative Value Guide is an important resource used by those who submit claims for anesthesia services. Keeping it up-to-date and reflective of current anesthesia practice helps ensure it continues to be a valuable source of information.