From the CEO

Medi-Cal Labor Epidural Payments Improved—Maybe

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Low payments for labor epidurals (CPT code 01967) provided for Medi-Cal patients has been a sore point for anesthesiologists for many years. In 1999, because of the CSA's efforts in the legislature and grass roots advocacy, the conversion factor for obstetrical anesthesia services was increased to $17.06. However, because the billing rules for labor epidurals were very restrictive, the increased conversion factor resulted in only a nominal increase in anesthesiologists' revenue for those services.

According to the Medi-Cal billing manual, only "time in attendance" was billable by the anesthesiologist. Although the manual did not define time in attendance as "face-to-face" time, the billing example appeared to allow no other interpretation. For many anesthesiologists, this translated to billing only the base units and the first hour of time because individual subsequent periodic checks of the patient did not reach the threshold for billing a time unit and the documentation requirement was felt to be onerous. A commonly used method that did not trigger audits was billing basic units + first hour of time + one unit per hour thereafter.

In recent years, compliance issues became more worrisome, with significant penalties threatened for each incidence of "overbilling." Some billing services began requiring detailed documentation for billing time units and refused to bill without it. Their concerns about compliance violations prompted this strict adherence to the Medi-Cal billing rules, resulting in a sense of urgency to establish a fairer and less onerous methodology for billing labor epidurals.

The ASA RVG does not recommend one billing method over another but lists four common methods. These include:

1. Basic units plus time units (insertion through delivery), subject to a reasonable cap.
2. Basic units plus one unit per hour for neuraxial analgesia management plus direct patient contact time (insertion, management of adverse events, delivery, removal).

3. Incremental fees (e.g., 0-2 hrs, 2-6 hrs, > 6 hrs).
4. Single fee.

In 2005, the CSA House of Delegates directed the leadership to consider advocating for a flat payment rate. CSA Legislative Counsel and Advocate Bill Barnaby Sr. and Jr. made initial contact with representatives at the Department of Health Services and learned that DHS would not consider such a radical change in the billing methodology. CSA leadership then considered other approaches and decided to go forward with a proposal to permit billing basic units + insertion time + one unit per hour for oversight of the laboring patient, without documentation of face-to-face time.

In April 2006, CSA representatives R. Lawrence Sullivan, Jr., M.D., Kenneth Y. Pauker, M.D., William Barnaby Sr. and Jr., and Barbara Baldwin met with two DHS Medical Directors, Drs. Fulton Lipscomb and Steven Parry, and conveyed the unfairness of the onerous documentation requirements which result in miniscule compensation for anesthesiologists. The DHS representatives informed us that their interpretation of the term "time in attendance" did not mean face-to-face time, but a broader definition that included the anesthesiologist's availability to be at the patient's bedside in short order. We pointed out that the billing example reflected the CSA's interpretation and requested that we be permitted to draft new language that reflects the medical directors' interpretation.

It took a few months to arrive at the final suggested language and submit it to DHS for consideration. The proposed language redefined time in attendance and articulated a DHS requirement that no more than four units per hour could be billed for concurrent labor epidurals. In September 2006, the DHS published the modified billing rules, which incorporate the CSA language with a few additional phrases. The DHS language was of great concern to some CSA leaders because it seemed to confine the anesthesiologist to the immediate vicinity of the labor and delivery suite and also noted that no more than four units per hour should be billed, including private patients.

The following is the revised portion of the Medi-Cal anesthesia billing manual that shows the key language italicized in the section "Time in Attendance" with the patient. Space limitations preclude printing the entire rule and members are urged to review it at **http://files.medi-cal.ca.gov/pubsdoco/publications/masters-MTP/Part2/anest_m00o03.doc**. Examples of billing concurrent services illustrate the DHS' requirement that not more than four time units per hour be billed.

Start, Stop and Total	Anesthesia start and stop times (in military time format) and the total
Anesthesia Time	Anesthesia time must be documented in the *Remarks* area/*Reserved For Local Use* field (Box 19) of the claim. Claims will be denied if the start and stop times are not indicated. If the start and stop time is less than the total quantity billed (in the *Service Units/Days or Units* box), the claim will be reimbursed according to the start and stop time. **Note:** Claims billing for more than 40 units of time (10 hours) require that an anesthesia report be attached to the claim.
"Time in Attendance"	If billing for obstetrical regional anesthesia (CPT-4 code 01967).
With the Patient	In addition to the documentation requirements noted above, providers also must document "time in attendance" in the *Remarks* area/*Reserved for Local Use* field (Box 19) of the claim. Claims without such documentation will be denied. **Only time in attendance with the patient may be billed.** *"Time in attendance" is time when the anesthesiologist or Certified Registered Nurse Anesthetist (CRNA) monitors the patient receiving neuraxial labor analgesia, and the anesthesiologist or CRNA is readily and immediately available in the labor or delivery suite. If the actual time in attendance is less than the total quantity billed (in either the Service Units or Days or Units box), the claim will be reimbursed for the time in attendance with the patient. If two or more patients receive neuraxial analgesia concurrently, no more than four total time units per hour may be billed and must be apportioned among the claims, including claims to other insurance carriers.*

Billing services were notified of the change in the rules and some requested clarification of the language regarding concurrent billing, particularly as it relates to managed care plans and contracted methods of payment. Additionally, some noted programming challenges in their billing software to comply with the limit on time units per hour.

The CSA board decided that the DHS medical director should be approached to address the potential problems that could result from the restrictive language. An action item was adopted at the September 2006 CSA board meeting stating,

"**RESOLVED,** that CSA finds the new DHS rules regarding the billing of Medi-Cal patients receiving neuraxial labor analgesia, while addressing our initial concerns, may create additional problems and unintended consequences, and be it

RESOLVED, that the CSA Board direct the President, with the assistance of legal and legislative counsel, to request the DHS to refine these rules, particularly regarding the term "immediately available in the labor or delivery suite" as a requirement for billing, and also references to the billing of non-Medi-Cal patients who might be receiving neuraxial labor analgesia concurrently with Medi-Cal patients." (402-1) Sept. 30, 2006

In follow-up to that instruction, we asked Dr. Parry for clarification of the term *"readily and immediately available in the labor or delivery suite"* and whether billing for concurrent services could be simplified by billing one time unit per hour up to four units per hour. Dr. Parry advised that the term Labor and Delivery Suite is not narrowly defined as the room in which the patient is laboring, but includes the area such as the "floor," call area, or wing. A key point is that an anesthesiologist who is covering labor and delivery should be in house and directly responsible for the anesthesia of the laboring patients and should not be doing a different case while billing for a labor epidural at the same time. Although "readily" and "immediately" are defined differently by the Medicare program, the DHS does not differentiate between them, nor does it impose a set response time.

In regard to the billing no more than four units per hour, providers may bill one unit per hour for up to four patients to simplify billing. Dr. Parry noted that what matters is how many patients are in labor and how much of the hour is spent taking care of the patient. Private contracted rates are not of concern to the Medi-Cal program.

With those clarifications, anesthesiologists may now:

1. Be in attendance without being in the patient's room, as long as an anesthesiologist is readily and immediately available to the patient,
2. Submit claims with start and stop times without detailing face-to-face time with the patient and not risk a compliance violation,

3. Bill up to four time units per hour for concurrent services, allocating one time unit per hour per patient,
4. Bill continuous time up to four time units per hour if one epidural is in place for a Medi-Cal patient.

These changes should result in increased payments for anesthesiologists, particularly those who waived billing time units due to onerous documentation requirements. By now the billing services should have some experience with submitting claims using the new billing rules. Check with your own to see if your bottom line has increased for Medi-Cal labor epidural services.