In an effort to assist our growing Anesthesia population, MEDDATA (MDS) has developed a specific Client Newsletter related to anesthesia billing and updates. This newsletter will address specific topics, questions posed by providers and staff, Insurance carrier updates, billing guidelines, as well as other subject matters requested by our providers; all related specifically to anesthesia.

Providers and staff are encouraged to submit topic requests and/or questions for inclusion in future newsletters to adminservices@medtronsoftware.com.

Anesthesia Care Team (ACT)

The Anesthesia Care Team (ACT) includes both physicians and nonphysicians. Often patients and even some other medical specialties do not understand what an ACT is as they don’t always understand the concept and inner workings of the ACT. The anesthesia care team is no different from any other team approach in health care, in that each member of the team has an obligation to accurately identify themselves to patients and family members and document their actions in the medical record.

Almost all anesthetics in the U.S. are delivered by physician anesthesiologists or by non-physician anesthesia providers directed by a physician anesthesiologist. The terms “direction” and “supervision” with regard to the role of the physician anesthesiologist are used in the context of billing for anesthesia services and outside the scope of this article. Regardless of the term used, the care of the patient is ultimately the responsibility of the physician anesthesiologist.

Anesthesia care is provided by an anesthesia practitioner who may be a:

- physician
- anesthesiology resident and fellow (billed under an Anesthesia Teaching Provider (TP))
- certified registered nurse anesthetist (CRNA) with or without medical direction
- anesthesia assistant (AA) with medical direction

Sources:
https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
http://anesthesiacareteam.com/

Two Providers - Same Case

Occasionally, two MD anesthesia providers will be needed on the same case at the same time. This could be due to the complexity of the case, i.e., trauma cases. Some Insurance carriers may allow both providers to bill for their time if the documentation supports the need for both providers and it is medically necessary.

Both providers should document the factors involved and specifically list what was done by each provider in the medical record and document the medical necessity, i.e., why two providers were required.

Sources:
Anesthesia Care ‘Package’

Types of anesthesia include local, regional, epidural, general, moderate conscious sedation, and monitored anesthesia care (MAC), however only three of these are billable for timed anesthesia cases. The anesthesia care package for timed anesthesia cases consists of preoperative evaluation, standard preparation and monitoring services, administration of anesthesia, and post anesthesia recovery care. The anesthesia practitioner assumes responsibility for anesthesia and related care rendered in the post-anesthesia recovery period until the patient is released (transferred) to the care of the surgeon or another physician in the post anesthesia care unit (PACU).

Preoperative evaluation includes a sufficient history and physical examination so that the risk of adverse reactions can be minimized, alternative approaches to anesthesia planned, and all questions regarding the anesthesia procedure by the patient or family are answered. It is standard medical practice for an anesthesia practitioner to perform a patient examination and evaluation prior to surgery. This is considered part of the anesthesia service and is included in the base unit value of the anesthesia ‘billing’ code. The evaluation and examination services are not reported (included) in the anesthesia time and cannot be billed separately from the anesthesia care package. The patient pre-anesthesia evaluation or re-evaluation encounter (per ASA), must be completed and documented within 48 hours immediately prior to the delivery of the first dose of medication(s) given for the purpose of inducing anesthesia.

The time spent reviewing the patient’s medical record prior to surgery is not billable anesthesia time. This is considered part of the preoperative evaluation which is compensated through the procedure’s base units, not the anesthesia time units.

Examples of integral services of the anesthesia care package, include but are not limited to:

- Transporting, positioning, prepping, draping of the patient for satisfactory anesthesia induction/surgical procedures.
- Placement of external devices including, but not limited to, those for cardiac monitoring, oximetry, capnography, temperature monitoring, Electroencephalography (EEG), Central Nervous System (CNS) evoked responses (e.g., Brainstem Evoked Response (BSER)), Doppler flow.
- Placement of peripheral intravenous lines for fluid and medication administration.
- Placement of airway (e.g., endotracheal tube, orotracheal tube).
- Laryngoscopy (direct or endoscopic) for placement of airway (e.g., endotracheal tube).
- Placement of naso-gastric or oro-gastric tube.
- Intra-operative interpretation of monitored functions (e.g., blood pressure, heart rate, respirations, oximetry, capnography, temperature, EEG, BSER, Doppler flow, CNS pressure).
- Interpretation of laboratory determinations (e.g., arterial blood gases such as pH, pO2, pCO2, bicarbonate, complete blood count (CBC), blood chemistries, lactate) by the anesthesiologist/CRNA.
- Nerve stimulation for determination of level of paralysis or localization of nerve(s).
- Insertion of urinary bladder catheter.
- Blood sample procurement through existing lines or requiring venipuncture/arterial puncture.

Routine postoperative evaluation is included in the base unit for the anesthesia service. If this evaluation occurs after the anesthesia practitioner has safely placed (transferred) the patient under postoperative care, neither additional anesthesia time units nor evaluation and management codes shall be reported for this evaluation.

Sources:
https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
https://www.aapc.com/blog/26128-anesthesia-startstop-time-accuracy-counts/
http://www.asahq.org/~media/Sites/ASAHQ/Files/Public/Resources/standards-guidelines/standards-for-postanesthesia-care.pdf

① ‘Preeval’ evaluation and exam may be billed if surgery is cancelled.
**Preoperative Evaluation**

Per the American Society of Anesthesiologists (ASA), published literature does not provide a standard definition for preanesthesia evaluation. ASA is defining the preanesthesia evaluation as the process of clinical assessment that precedes the delivery of anesthesia care for surgery and for nonsurgical procedures which is the responsibility of the anesthesiologist.

Preanesthesia evaluation consists of the consideration of information from multiple sources that may include the patient’s medical records, interview, physical examination, and findings from medical tests and evaluations. During the preanesthesia evaluation process, the anesthesiologist may choose to consult with other healthcare professionals to obtain information or services that are relevant to perioperative anesthetic care.

The Anesthesia preoperative exam may include:

- **Identifying Statement** - Name, age, sex, planned surgery and indication for procedure, surgeon
- **Elements that must be performed within the 48-hour timeframe (per ASA):**
  - Past, Family, and Social History (PFSH)
  - Medical History, Allergies, Medications
  - Past Anesthetic History - identification of potential anesthesia problems, particularly those that may suggest potential complications or contraindications to the planned procedure - problems with airway management, difficult IV access, prolonged emergence, post-operative nausea/vomiting
  - Interview, if possible given the patient’s condition, and examination of the patient.
- **Elements that must be reviewed and updated as necessary within 48 hours, but which may also have been performed during or within 30 days, in preparation for the procedure (per ASA):**
  - Notation of anesthesia risk according to established standards of practice
  - Development of the plan for the patient’s anesthesia care, including the type of medications for induction, maintenance and post-operative care and discussion with the patient (or patient’s representative) of the risks and benefits of the delivery of anesthesia
  - History of Present Illness (HPI)
  - Review of Systems (ROS)
  - Physical Exam
    - General - weight and height, vitals, Body Mass Index (BMI), jaundice
    - Airway - Mallampati score/mouth opening, cervical spine mobility, temporomandibular joint mobility, teeth (especially diseased/loose/artificial), thyromental distance
    - Pulmonary - auscultation, thoracic shape and expansion, oxygen saturation on room air
    - Cardiovascular System - auscultation for murmurs, pulses, venous access sites, edema, venous pressure, BP (including postural drop if relevant)/heart rate/rhythm
    - Central Nervous System (CNS) - motor & sensory function, cognitive function
    - Hematologic - petechiae, bruising, clinical evidence of anemia

The assessments made in the process of preanesthetic evaluation may be used to educate the patient, organize resources for perioperative care, and formulate plans for intraoperative care, postoperative recovery, and perioperative pain management.

An assessment of readily accessible, pertinent medical records with consultations, when appropriate, should be performed as part of the preanesthetic evaluation before the day of surgery for procedures with high surgical invasiveness. For procedures with low surgical invasiveness, the review and assessment of medical records may be done on or before the day of surgery by anesthesia staff. Test results obtained from the medical record within 6 months of surgery generally are acceptable if the patient’s medical history has not changed substantially. More recent test results may be desirable when the medical history has changed or when a test results may play a role in the selection of a specific anesthetic technique.

Sources:
https://www.openanesthesia.org/overall_preoperative_evaluation_anesthesia_text/
http://ether.stanford.edu/ca1_new/ca1_preop_new1.html
http://www.sarasotaanesthesia.com/PoliciesFolder/AdvisoryForPreAnesEval.htm
Anesthesia Documentation of Start and Stop Time
(for billing Anesthesia (ASA) timed services)

The Centers for Medicare & Medicaid Services (CMS) defines surgical anesthesia time as the continuous, actual presence of the anesthesiologist or CRNA. Surgical anesthesia time begins when the physician or CRNA starts preparing the patient for the anesthesia procedure - in the operating room or equivalent area—and ends when the anesthesia practitioner is no longer in personal attendance.

The CPT® definition is similar: “Anesthesia time begins when the anesthesiologist begins to prepare the patient for the induction of anesthesia 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 may be safely placed under postoperative supervision.”

In both definitions, time is counted from the moment the practitioner - having completed the preoperative evaluation—starts an intravenous line, places monitors, administers pre-anesthesia sedation or otherwise physically begins to prepare the patient for anesthesia. Time continues through the case and the period during which the practitioner accompanies the patient to the post-anesthesia recovery unit (PACU). Time stops when the practitioner releases, i.e., transfers, the patient to the care of the PACU personnel.

Both definitions imply that anesthesia time is a continuous time period from the start of the anesthesia service to the end of the anesthesia service and should be exact times, i.e., anesthesia personnel in constant attendance.

Too often, groups round to the nearest five-minute increment, or worse, estimate the time involved based on past experience. A good indication of potentially inappropriate rounding is if more than 20% of a practice’s start and stop times are fixed on five-minute intervals.

Other time calculation obstacles:
In situations where the anesthesiologist has begun preparing the patient for induction, but the surgeon is temporarily unavailable and the anesthesiologist leaves the patient under the observation of non-anesthesia personnel, this is considered discontinued time and should be documented in the anesthesia record and subtracted from total time.

The provider can add blocks of time around an interruption in anesthesia time as long as the provider is furnishing continuous anesthesia care within the time periods around the interruption. The information should be documented so that an auditor can see the continuous and discontinuous periods of anesthesia.

Another example of discontinuous time is when an intravenous (IV) is started in the induction room, but there is a break before induction of anesthesia in the operating room. As long as there is continuous monitoring of the patient within the blocks of anesthesia time, those blocks may be aggregated.

Arterial and/or central lines are billed separately as are regional blocks and/or epidurals when ordered by the surgeon for post-op pain, i.e., not used as the mode of anesthesia and should be coded as separate billable “procedures”. These services are not included in the reported anesthesia time and are billed separately. As with any billable “procedure” documentation must support and define the services provided, and who provided the services.

Sources:
https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
https://www.aapc.com/blog/26128-anesthesia-startstop-time-accuracy-counts/
Anesthesia Timed Billing

The reimbursement rate for anesthesiology timed services is calculated by adding the Base Units associated to the surgery CPT code and *Time Units and if applicable, additional modifier units associated with the case, and then multiplying the sum total Anesthesia Units by the applicable Insurance carrier’s Conversion Factor (CF).

- “Base units” are used to compute allowable amounts for anesthesia timed services billed under CPT/ASA codes 00100 to 01999. Base units are relative value units assigned by CMS to each anesthesia procedure code based on the Surgeon’s CPT code. Per the 2019 ASA Relative Value Guide (RVG) the usual anesthesia services included in the Base Value Units include the usual pre-operative and post-operative visits, the administration of fluids and/or blood products incident to the anesthesia care and interpretation of non-invasive monitoring (ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry).

- A “Time Unit” is a measure of each 15-minute interval, or fraction thereof, during which anesthesiology services are performed. This value must be calculated based upon the length of time spent by the anesthesia provider(s) rendering the service.

- “Additional Units” are available for Physical Status and Field Avoidance/Positioning modifiers and/or add-on (+) CPT codes for Qualifying Circumstance (99100, 99116, 99135, 99140).

- If a modifier is used, it is added to ASA code billed to indicate the patient's condition/position at the time anesthesia was administered.

- “Conversion Factors” (CF) are negotiated $ rates between the provider and each Insurance carrier for payment per anesthesia unit.

When multiple surgical procedures are performed during a single anesthetic administration, only the anesthesia ASA code with the highest base unit value billed. The time reported is the combined total for all procedures. Add-on anesthesia ASA codes are an exception to the 'one ASA code billed' policy, i.e., billing two ASA codes for a case may exist in burn cases and if labor for a vaginal delivery results in a c-section.

Anesthesiologist services are billed as one charge line item (with appropriate modifiers) or if Medically Directing a CRNA, billed as two charge line items for one case (with provider (MD/CRNA) specific modifiers).

Sources:
https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
Physical Status Modifiers (P1-P6)
(affixed to ASA timed procedures)

The American Society of Anesthesiologists (ASA) doesn't provide solid definitions for use of physical status modifiers as their use is based on clinical decisions the anesthesia provider makes for each patient, however they do provide some examples (listed below). Physical status modifiers are also listed in the CPT book to distinguish among various levels of complexity of the anesthesia service provided.

Most anesthesia services call for a P1, P2, or P3 modifier. Insurance carriers require clear documentation in the medical record to support use of ‘P’ modifier > P2 as many Insurance carriers will require more information to support the claim.

The ‘P’ modifiers (MOD) are appended to the timed anesthesia service/procedure codes (00100-01999).

<table>
<thead>
<tr>
<th>MOD</th>
<th>Units</th>
<th>Definition</th>
<th>ASA</th>
<th>Examples</th>
</tr>
</thead>
</table>
| P1  | 0     | A normal healthy patient            | I   | Healthy, non-smoking, no or minimal alcohol use
|     |       |                                        |     | No organic, physiologic, or psychiatric disturbance; excludes the very young and very old; healthy with good exercise tolerance |
| P2  | 0     | A patient with mild systemic disease | II  | Mild diseases only without substantive functional limitations. Current smoker, social alcohol drinker, pregnancy, obesity (30 < BMI < 40), well-controlled DM/HTN, mild lung disease |
| P3  | 1     | A patient with severe systemic disease | III | Substantive functional limitations; One or more moderate to severe diseases. Poorly controlled DM or HTN, COPD, morbid obesity (BMI ≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, ESRD undergoing regularly scheduled dialysis, premature infant PCA < 60 weeks, history (>3 months) of MI, CVA, TIA, or CAD/stents |
| P4  | 2     | A patient with severe systemic disease that is a constant threat to life | IV  | Recent ( < 3 months) MI, CVA, TIA, or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, sepsis, DIC, ARD or ESRD not undergoing regularly scheduled dialysis |
| P5  | 3     | A moribund patient who is not expected to survive without the operation | V   | Ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction |
| P6  | 0     | A declared brain-dead patient whose organs are being removed for donor purposes | VI  | |

Sources:
https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/anest_m00o03.doc
Qualifying Circumstances (QC) *(separate billing line item code)*

Per the 2019 CPT Book, many anesthesia services are provided under particularly difficult circumstances, depending on factors such as extraordinary condition of the patient, notable operative conditions, and/or unusual risk factors. Qualifying circumstances represent the provision of anesthesia services that necessitate the skills of a physician beyond those usually required.

Qualifying circumstances codes are not be reported alone, they are billed in addition to the anesthesia care package, ASA timed code and are reported with a separate CPT code.

Qualifying Circumstance billed as an add-on code (reimbursed as additional units):
- 99100 (1 unit) - patient who is younger than age 1 or older than age 70
- 99116 (5 units) - complicated by utilization of total-body hypothermia
- 99135 (5 units) - complicated by utilization of controlled hypotension
- 99140 (2 units) - complicated by emergency conditions only

Some Insurance carriers specify that the qualifying circumstances codes can only be billed by the practitioner who is administering the anesthesia. In cases where a CRNA is administering anesthesia under the supervision of an anesthesiologist, the CRNA may bill the qualifying circumstances codes, but the supervising anesthesiologist may not.

Anesthesia Qualifying Circumstances (99100, 99116, 99135, 99140) typically do not require prior authorization. Authorizations for anesthesia services in general are included in the surgeon or hospital authorization.

Sources:
https://hmsa.com/portal/PROVIDER/zav_pel.ph.ANE.600.htm

**QC CPT: 99100 - Anesthesia to Patients Age <1 or >70**

Patients of extreme age often require additional monitoring, thus CPT created a qualifying circumstance code to allow providers to bill for the additional resources required.
CPT 99100 cannot be billed with surgeon/ASA codes that have these ages included in the description, i.e., not used with 00326, 00561, 00834, 00836.

Source:

**QC CPT: 99116 - Anesthesia Complicated by Utilization of Total-Body Hypothermia**

During a procedure in which an anesthesia provider administers anesthesia to the patient, the provider induces hypothermia in the patient, affecting the complexity of the anesthesia service.

The provider most commonly induces hypothermia during intracranial surgeries. The provider must document inducing the hypothermic state at the time of providing the anesthesia service as well as the medical record to support use of this code.

Source:
https://coder.aapc.com/cpt-codes/99116
QC CPT: 99135 - Anesthesia Complicated by Utilization of Controlled Hypotension

Deliberate hypotensive or Controlled hypotension anesthesia is a safe and effective way to reduce bleeding, reduce the need for blood transfusions, and reduce surgical time which has been used for many years. It also reduces the need for blood transfusion when the anesthesiologist anticipates excessive blood loss such as during procedures on the head, face or upper thorax, and scoliosis surgery. It has been indicated in oromaxillofacial surgery (mandibular osteotomy, facial repair), endoscopic sinus or middle ear microsurgery, spinal surgery and other neurosurgery (aneurysm).

Controlled hypotension is defined as a reduction of the systolic blood pressure (BP) to 80–90mm Hg, a reduction of mean arterial pressure (MAP) to 50–65mm Hg or a 30% reduction of baseline MAP. The anesthesiologist usually inserts an arterial line, or A-line during hypotensive anesthesia to monitor the patient's BP. Documented A-Lines (such as CPT 36620) are separately billable during a timed anesthesia service.

Include in the documentation to support billing CPT 99135 the pharmacological agents used for controlled hypotension include those agents that can be used successfully alone and those that are used adjunctively to limit dosage requirements and, therefore, the adverse effects of the other agents.

Hypotensive episodes are common during anesthesia, and controlled hypotension was once even a popular technique for reducing blood loss during surgery. However, because of the unpredictability of cerebral and other organ damage resulting from hypotension, most modern anesthesiologists employ controlled hypotension very sparingly, or not at all.

The practical and safe advice is to treat all patients in the same way - use the thresholds for measurable minimum BP (cerebral blood flow and organ blood flow are actually the important parameters, however providers cannot measure these things).

The practical practice guidelines for hypotension during anesthesia include:

✦ Carefully examine the chart of the patient for blood pressures (BP) measured during rest.
✦ Patients with known carotid stenosis, known valvular disorders, known heart failure, known fixed cardiac output, and known severe coronary artery stenosis should not be subjected to hypotension. These patients may well develop cerebral or myocardial ischemia.
✦ A safe BP for patients without any of the above conditions is to keep the BP at a level equal to, or higher than 2/3 of the known resting mean arterial BP.
✦ Patients in semi-reclining or sitting positions are at especial risk (BP decreases 2 mmHg for every 2.5 cm height above the point of measurement).
✦ A very practical way of checking the adequacy of brain BP is to simply feel for pulsations of the superficial temporal artery just in front of the tragus of the ear. This position is about the same level as the brainstem. If you can feel pulsations, then there is very likely perfusion of the brainstem, but if pulsations are absent, then the patient is very likely hypotensive with inadequate brain perfusion.

Sources:
http://www.anesthesiaweb.org/hypotension.php
An emergent condition is one qualifying circumstance that may significantly affect the character of the anesthesia service provided.

An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part. Providers should document the emergent condition in the medical record as some carriers require supporting information to be submitted on the CMS 1500 claim form (box 19).

When to Report and When NOT to Report
Knowing what qualifies as emergency conditions is a common stumbling block for providers.

Below are some common things to consider before reporting 99140 for an emergent condition.

- Before declaring this emergency code appropriate, providers should watch for evidence that the patient was in observation or was admitted for a while without any major change in status before surgery. Providers may be unlikely to meet the CPT® definition of emergency if there was a delay before treatment. Ask yourself whether delaying treatment would have led to a significant increase in risk to the patient’s life or limb. If not (or if you don’t have enough documentation to support that stance), don’t submit 99140.

- A patient admitted via the emergency department may qualify for 99140, but not always. Remember to code based on the conditions specific to the patient, not simply the hospital department involved. A typical example is the scenario of pregnant women who are instructed to present to the emergency room when they’re in labor. Some of those women may meet the definition of emergency conditions, but not all of them will.

- Declaring anything outside of normal office hours an “emergency” is not correct. Not all people seeking treatment at night or on the weekend meet the definition of emergency.

- If documentation shows someone was in respiratory distress or suffered serious trauma, providers may have a good case for reporting the code. Other patients requiring anesthesia services may be farther down the triage line, and the anesthesiologist would need to document clearly why treatment delay would threaten the patient’s life or a body part to prove emergency conditions in line with 99140 requirements.

Sources:
https://blog.supercoder.com/my-skill-sharpener/3-times-anesthesia-coders-should-not-report-99140/
http://anesres.com/reimbursement/how-to-bill-for-anesthesia-for-an-emergency-of-short-duration/
http://www.supportmed.com/emergency-code-99140/codingtips/2013/10/458/
https://hmsa.com/portal/PROVIDER/zav_pel.ph.ANE.600.htm
Billing for Anesthesia Timed Services

Anesthesia services are billed using ASA codes that are cross walked from the surgeon’s CPT code. The Surgeon is typically paid a flat fee schedule amount per Insurance carrier for the service while the Anesthesiologist is paid based on time (TM); typically 15 minutes equals 1 TM unit.

Example:
Surgeon CPT Code – 26852 Arthrodesis Joint w/Auto Graft

*Surgeon is typically paid a flat *fee schedule amount per Insurance carrier

Fee schedule amount for LA Medicaid CPT: 26852: ~$577, LA Blue Cross ~$1,190

Anesthesia (ASA) Code 01830 is assigned

i.e., cross walked from surgeon’s CPT code 26852 per RVU Guide

Additional Anesthesia Units for Physical Status of P3 assigned 1 Additional unit per CMS

Time of Case: 6:00 am - 7:15 am = 75 min

*Time interval for Anes Unit assignment = 15 min or part there of, i.e., 75/15 = 5 Time units

Insurance carriers differ greatly in their use of rounding conventions even to what decimal place rounded.

\[(\text{ASA Base units} + \text{*Time units} + \text{Add’l Modifier Units}) \times \text{Conversion Factor (CF)}\]

\[
\left( \frac{3}{9} + \frac{5}{9} + \frac{1}{9} \right) \times \text{CF} = \text{Allowed Amount}
\]

LA Medicaid CF ~$15  \(9 \times \$15 = \$135\)

LA Blue Cross CF ~$45  \(9 \times \$45 = \$405\)

If MD performed alone:  Billed as: 01830 AA P3
If Resident with MD:     Billed as: 01830 AA P3 GC

Sources:
http://static.aapc.com/a3c7c3fe-6fa1-4d67-8534-a3c9e8315fa0/e0bdf19e-6a7e-4179-9300-8acc467f224e/d8a4f0fd-938b-458d-a1cd-0f1e2966e6d6.pdf
Medical Direction of a CRNA or Resident

When anesthesiologists work with other qualified anesthesia providers, such as certified registered nurse anesthetists (CRNA) or anesthesia assistants (AA), the anesthesiologists must follow special documentation requirements. The medical direction rules apply when an anesthesiologist works with one to four other qualified providers in overlapping cases. If more than four cases overlap, even for a single minute, this is considered to be medical supervision, not direction.

According to CMS, medical direction is reported by appending specific anesthesia billing modifiers to the anesthesia code. These modifiers are reported by the medically directing anesthesiologist (QK, QY) as well as the other qualified anesthesia providers. These modifiers include:

- QK: Medical direction of 2, 3 or 4 concurrent anesthesia procedures involving qualified individuals
- QY: Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist
- QX: CRNA service; with medical direction by a physician
- GC: Service has been performed in part by a resident under the direction of a teaching physician

Medical direction is limited to no more than four concurrent cases. When counting concurrency, ALL cases count – not just the ones in which the patient is a Medicare beneficiary.

The American Society of Anesthesiologists (ASA) and Medicare have agreed on seven elements that must be documented for the anesthesiologist to bill medical direction services:

1. Perform a pre-anesthetic examination and evaluation.
   The anesthesiologist must personally perform an exam and evaluation prior to the anesthetic session. The specific system(s) or body area(s) examined and the findings must be documented. Although there is no timeframe documented, most expect the pre exam to be done within 48 hours of surgery/procedure.

2. Prescribe the anesthesia plan.
   The anesthesiologist must personally decide on the appropriate anesthetic for the procedure (e.g., general anesthesia, regional block, etc.), and must document that decision.

3. Personally participate in the most demanding procedures in the anesthesia plan, including (if applicable) Present for Induction (PFI) and Present for Emergence (PFE).
   If there are other demanding aspects of the service, depending on the type of anesthesia, the anesthesiologist must be in the room during those services and must document his/her presence and participation.

4. Ensure a qualified individual performs any procedures in the anesthesia plan that the anesthesiologist does not personally perform.
   Everyone who participates in the service must sign in to the case, appending his/her license or certification (e.g., MD, CRNA, AA).

5. Monitor the course of anesthesia administration at frequent intervals.
   Although it is not necessary for the anesthesiologist to be in the room for the entire case, he/she must provide appropriate monitoring throughout the case. Monitoring means actual presence in the room where anesthesia is being administered.

Continued next page...
6. Remain physically present for all key and critical portions of the procedure, and be available for immediate diagnosis and treatment of emergencies. The anesthesiologist cannot be personally providing anesthesia care or handling other services that take more than a few minutes, or that take him or her out of the immediate area where the anesthesia services are being provided.

7. Provide post-anesthesia care as indicated.
   The anesthesiologist should document any services performed during post-anesthesia time, especially if the patient requires more care due to adverse reactions. Even if the patient is doing fine, the anesthesiologist is expected to document, at a minimum, that the patient is safe to transfer to someone else.

   The anesthesiologist must personally document the seven components. It’s not adequate for someone else to document that the anesthesiologist did the work, or was present. CMS requires documentation of availability throughout the case and presence for critical portions of the anesthesia, including induction and emergence. The anesthesiologist can document availability in the anesthesia record with a note, such as “available throughout.”

   One does not need to repeat a previous evaluation and can note the resident’s, CRNA’s, AA’s, or PA’s information, but writing “agree with above” is not sufficient. The anesthesiologist must also document his/her anesthetic care plan. This information must be documented whenever the anesthesiologist is performing medical direction, no matter what type of anesthesia or analgesia is provided, including MAC.

   Other than the anesthesiologist not being allowed to document the required information before the service is performed, there are no specific rules about how monitoring must be documented. For paper records, an anesthesiologist might initial the chart tracking the patient’s vital signs, administration of drugs, and other information each time he or she comes into the room and checks on the patient.

   In electronic records, the anesthesiologist may add a statement that he or she was present for monitoring each time he or she is in the room checking on the patient, or may document at the end of the record that he or she monitored the patient throughout the course of the case.

   Example anesthesia billing under medical direction (see prior section on “Billing for Anesthesia Timed Services” in this Newsletter):

   \[(ASA \text{ Base units } + \text{*Time units } + \text{Add’l Modifier Units}) \times \text{Conversion Factor (CF)}\]

   - If MD performed alone: Billed as: 01830 AA P3
   - If MD with 1 CRNA (medical direction) - MD charge line: Billed as: 01830 QY P3
   - If MD with 1 CRNA (medical direction) - CRNA charge line: Billed as: 01830 QX P3
   - If MD with 2-4 CRNA (medical direction) - MD charge line: Billed as: 01830 QK P3
   - If MD with 2-4 CRNA (medical direction) - CRNA charge line: Billed as: 01830 QX P3
   - If Resident with MD: Billed as: 01830 AA P3 GC

   Sources:
   https://www.aapc.com/blog/24070-follow-7-rules-for-billing-anesthesia-medical-direction/
Medical Direction During an Emergent Condition

CMS muddied the waters 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

Historically, ‘Immediately Available’ was confusing as there was no clear definition. In 2012, the ASA House of Delegates published this definition to assist providers:

“A medically directing anesthesiologist is immediately available if he/she is in physical proximity that allows the anesthesiologist to re-establish direct contact with the patient to meet medical needs and address urgent or emergent clinical problems. These responsibilities may also be met through coordination among anesthesiologists of the same group or department. Differences in design and size of various facilities and demands of the particular surgical procedures make it impossible to define a specific time or distance for physical proximity.”

One question posed by an anesthesiologist practicing in a group brought up a good point - what constitutes a short duration?

If an anesthesiologist is medically directing a patient in OR #1 and an emergency occurs that needs to be addressed in OR #2, is medical direction broken if the anesthesiologist begins the emergency case in OR #2 and remains there for 31 minutes, until an on-call CRNA relieves the anesthesiologist?

The emergency case is clearly an emergency (CPT code 99140) and we can assume that OR #2 is in the immediate area. Sources recommend providers look at the expected on-call response time as the relative duration. Most anesthesia groups that utilize from-home, on-call for CRNAs, expect them to arrive within 30 minutes of being contacted (group policy statement).

The above example would qualify for all three criteria and the case should be billed as medically directed and not subject to decreased reimbursement for broken medical direction (or supervision).

Sources:
http://anesres.com/reimbursement/how-to-bill-for-anesthesia-for-an-emergency-of-short-duration/
Post-Op Pain Management (Blocks)

There must be an indication in the medical record that the surgeon requested the post-op block; before CMS’s recent clarification, an anesthesiologist could simply state in the medical record “for post-op pain per surgeon request”. CMS concluded that the National Correct Coding Initiative (NCCI) instructions do apply to “postoperative pain management services” and that “it is the responsibility of the surgeon to document in the medical record the reason that he has referred to an anesthesiologist for assistance with postoperative pain management.” Therefore, the surgeon should record the actual request for a post-op pain block in the operating notes. The anesthesiologist should include in his/her documentation the clinical aspects as well and the reason for the block including time, drugs used, needle position, needle depth, location, etc. and contain an entry “for post-op pain per surgeon request”.

Chapter 2 of the National Correct Coding Initiative states, “Postoperative pain management services are generally provided by the surgeon who is reimbursed under a global payment policy related to the procedure and shall not be reported by the anesthesia practitioner unless separate, medically necessary services are required that cannot be rendered by the surgeon. Surgeons are reimbursed for routine post-operative pain management as part of their global fee, i.e., from Medicare Physician Fee Schedule Database the reimbursement is allocated (%) for The surgeon is responsible to document in the medical record the reason care is being referred to the anesthesia practitioner.” This recent direct response from CMS further clarifies and underscores CMS’s position that the surgeon must document why he is requesting a post-op pain block from anesthesia.

The NCCI further confirmed that epidurals and blocks for the management of postoperative pain are separately reportable (i.e., billable) and not bundled into the timed anesthesia service unless they are used as the method of administering the anesthesia used for the surgery, i.e., placed pre-, intra-, or postoperatively. **A BLOCK PERFORMED WITHOUT A DOCUMENTED REQUEST IS A BLOCK THAT CAN’T BE BILLED.**

A separate procedure note (medical record/template) is a good practice to clearly separate the post-op block from the mode of timed anesthesia used for the surgical procedure. Insurance carriers will need to see a surgeon’s request and a reason for why the block was performed.

Some suggest having the block performed in a separate room from where the patient received anesthesia prior to surgery to further indicate a clear distinction between the post-op pain block and the timed anesthesia used for the surgery. The area doesn't have to be a specific block room, just a separate area from where the patient receives anesthesia.

The variety of commonly used modalities for post-op pain management makes it imperative that providers understand the specific documentation and billing requirements of each option. Listed below are several common approaches and their corresponding general guidelines.

- **Intravenous Patient-Controlled Analgesia Management (IV PCA)** –
  Many Insurance carriers allow anesthesiologists to bill for daily post-op pain management. To bill, the billing provider must see the patient on a post-operative day and document a progress note to include a problem focused history and exam with straightforward medical decision making.

  The typical Evaluation & Management (E&M) CPT code billed for daily pain management is “subsequent inpatient visit” code 99231. See CMS E&M Guidelines:
  
  1995 Documentation Guidelines For Evaluation and Management Services
  1997 Documentation Guidelines For Evaluation and Management Services
  
  ASA 01996 - Daily hospital management of epidural or subarachnoid continuous drug administration
  Unlike most ASA codes, 01996 is not billed as a timed code. Insurance carriers pay as a flat fee (per a fee schedule) per day billed.
Patient-Controlled Epidural Analgesia (PCEA) – *imaging guidance is included in CPT 62325 and 62327*

If an epidural (CPT code 62324-62327) is placed for post-op pain and is not the primary mode of anesthesia, it may be billed separately from the timed anesthetic.

In addition, starting the day after the procedure, each calendar day of face-to-face epidural catheter management (01996) is billable, typically through day three (additional days may be billable even day of service if surgeon request and service is medically necessary).

Spinals/Duramorph – *imaging guidance is included in CPT 62321 and 62323*

If a spinal (CPT code 62320-62323) is placed for post-op pain and is not the primary mode of anesthesia, it may be billed separately from the anesthetic.

In addition, a follow-up visit may be billed the next calendar day, if medically necessary. The typical E&M CPT code billed for the daily service is “subsequent inpatient visit” CPT code 99231. Some Insurance carriers will bundle and deny any E&M service billed the day after timed anesthesia. For combined spinal-epidurals commonly used in OB cases, it is not appropriate to bill separately for the spinal injection, since the injection is typically performed via the epidural catheter/trocar.

Interscalene/Brachial Plexus Blocks –

If general anesthesia is used for an upper extremity surgery case, and an interscalene block (CPT code 64415 (single) - 64416 (continuous)) is placed for post-op pain, the block(s) may be billed separately from the timed anesthesia.

If a continuous block follow-up visits can be billed if applicable if the provider physically sees the patient on a subsequent calendar day.

The typical E&M CPT code billed for the daily service is “subsequent inpatient visit” CPT code 99231.

Femoral and Sciatic Nerve Blocks –

If a general anesthetic is used for a lower extremity surgery case, and a femoral block (CPT code 64447 (single), 64448 (continuous)) and/or sciatic (CPT code 64445 (single), 64446 (continuous)) nerve block is placed for post-op pain, then the block(s) may be billed separately.

If continuous infusion by catheter block(s), follow-up visits can be billed if applicable, if the provider physically see the patient on a subsequent calendar day.

The typical E&M CPT code billed for the daily service is “subsequent inpatient visit” CPT code 99231.

It is imperative that providers indicate if the block is separate and distinct from the primary mode of timed anesthesia used in the case when billing for post-op pain procedures.

**NOTE:** Groups should not check off both “general” and “regional” as the modes of anesthesia unless they are truly intending to do a combined “general-regional” technique, which would negate the separate billing of the block for post-op pain. Although most Insurance carriers will allow a post-op pain block to be used as an adjunct to a general anesthetic, if the block itself could have provided the entire anesthetic, then documentation of medical necessity for the “general” is recommended.

Per CMS requirements, anesthesiologists should continue to state clearly on the anesthesia record that the block is “for post-op pain per surgeon request”. Per the AMA, post-op pain blocks can be performed either pre-operatively, intra-operatively or post-operatively. However, post-op pain blocks performed prior to the induction of anesthesia are not to be included in billable anesthesia time and are billed as “flat fee” surgical procedures instead.

Sources:


https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

http://decisionhealth.com/static/app/app1603_web.pdf

**Adductor Canal Block**

The saphenous nerve block should be performed at the most distal level where the artery still lies immediately deep to the sartorius muscle, thus minimizing the amount of motor block of the vastus medialis; an adductor canal block is typically performed more proximally, around the mid-thigh level.

The adductor canal pain block for a single shot is reported using the code for femoral nerve code, i.e., CPT 64447 (WRVU: 1.50), Injection, anesthetic agent; femoral nerve, single; or CPT 64448 (WRVU: 1.63), Injection, anesthetic agent; femoral nerve, continuous infusion by catheter (including catheter placement).

This guidance was released in CPT Assistant November 2014. Prior to 2014, providers used peripheral nerve block code 64450. (WRVU: 1.13)

Sources:
http://decisionhealth.com/static/app/app1603_web.pdf

**Medically Unlikely Edits (MUE) - Maximum units of service that a provider would report under most circumstances for a single beneficiary on a single date of service**

**Ultrasound (U/S) Guidance**

CPT +76937 (WRVU: 0.30, MUE: 2) - Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, concurrent real-time ultrasound visualization of vascular needle entry, with permanent recording and reporting, i.e., billed with 36620, 36570, 36571, ...

CPT 76942 (WRVU: 0.67. MUE: 1) - Ultrasonic guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), imaging supervision and interpretation, i.e., billed with 64415, 64445, 64447, 64450, ...

Modifier 26 - Professional component of a service being billed was "interpretation only"

Ultrasound-guided needle placement is billed by the professional provider with a modifier 26 which requires additional documentation like that of a radiologist interpretation. The interpretation should include guidance used, vein entry site, tunneled/non-tunneled, subcutaneous pump (if in place), structure assessment, final catheter tip position, dispersion of the drug, effectiveness of the block, and patient age.

Ultrasound guidance requires a permanent recorded image(s) of the vascular access site to be included in the patient record as well as a documented description of the process either separately or within the procedure report.

American Medical Association (AMA)/CPT services clarified that CPT 76937 applies only to venous access procedures. The imaging includes pre-access assessment of venous patency and actual real time/dynamic visualization of needle passage to the venous lumen.

Multiple units of an ultrasound guidance code may be billed if medically necessary and clearly documented that ultrasound guidance was needed on the procedure(s) performed on different anatomical areas (per date of service).

For example, when there are two nerve blocks done on one extremity; a right axillary nerve block with a right musculocutaneous (upper arm) nerve block where the ultrasound guidance 76942 is used twice on the right side.

Sources:
Field Avoidance

Field avoidance and special positioning, are unique to anesthesia services although they are not specifically mentioned in the minimal section of Anesthesia Guidelines found in the Current Procedural Terminology® (CPT) Codebook, but they maybe considered as services under the Special Report section.

These unique circumstances are defined by the American Society of Anesthesiologists' Relative Value Guide® (ASA RVG) as "Any procedure around the head, neck, or shoulder girdle, requiring field avoidance, or any procedure requiring a position other than supine or lithotomy," and have “a minimum Base Value of 5, regardless of any lesser base value assigned to such procedure in the body of the Relative Value Guide®." Since the definition includes a minimum base value of five units, this automatically excludes reporting with anesthesia services having a base value of five or more units.

Field avoidance indicates that the anesthesia provider does not have access to the patient’s airway during surgery. This may be due to the nature of the case (i.e., face or shoulder surgery) or because the surgeon has the patient in a different position. Both field avoidance and unusual positioning make the case a higher risk for the patient and the anesthesia provider. For special positioning, surgeries performed in either the supine (patient is lying on their back) or lithotomy (patient is on their back with the hips and knees flexed and the thighs apart) are also excluded.

As there are many codes with a base value of fewer than five units, there is a good chance anesthesia providers will qualify for additional payment for some of the anesthesia services, providing the documentation supports the reported circumstance.

Significant changes just released regarding field avoidance.
The 2019 revision more broadly states: Whenever access to the airway is limited (e.g., 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 value assigned to such procedure in the body of the Relative Value Guide.

Sources:
http://www.anesthesiallc.com/publications/blog/entry/field-avoidance-and-special-positioning

Cancelled Cases

Procedures cancelled before induction must be reported using the correct Evaluation and Management (E&M) code related to the documentation of the pre anesthesia evaluation. The documentation should include the specific reason as to why the case was cancelled, such as case cancelled due to equipment failure.

Procedure cancelled after induction should be reported with the appropriate modifier:
- 53 (discontinued procedure),
- 73 (procedures discontinued prior to anesthesia), or
- 74 (procedures discontinued after anesthesia administration or after the procedure has begun), plus time.

If the Insurance carrier does not accept a modifier (most do not recognize modifier 53 in anesthesia), the case can be billed using the correct anesthesia code with the full base units for the procedure that was scheduled, plus total time that is documented on the anesthesia record, i.e., time would be relatively low since case was cancelled.

Sources:
https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
Monitored Anesthesia Care (MAC)

General Anesthesia (GA) refers to patients that are completely asleep and have an endotracheal tube down the throat. By definition GA is when a patient loses their protective airway reflexes. When they are so sedated that they can no longer swallow saliva, gag reflex has been obtunded, may quit spontaneously breathing, and may obstruct easily.

Monitored Anesthesia Care (MAC) anesthesia refers to patients that are not completely asleep and were not intubated. By definition MAC is when the patient receives varying levels of sedation to achieve ideal procedural conditions with patient interaction.

MAC is a type of sedation that is administered through an IV which may be performed by an anesthesia practitioner who administers sedatives, analgesics, hypnotics, or other anesthetic agents so that the patient remains responsive and breathes on his own. MAC makes a patient sleepy and calm during a procedure and provides anxiety relief, amnesia, pain relief, and comfort.

While the patient may be heavily sedated, this type of anesthesia is different from general anesthesia because the patient is not chemically paralyzed, nor do they require assistance with breathing. MAC involves patient monitoring sufficient to anticipate the potential need to administer general anesthesia during a surgical or other procedure. MAC requires careful and continuous evaluation of various vital physiologic functions and the recognition and treatment of any adverse changes.

While MAC may include the administration of sedatives and/or analgesics often used for Moderate Sedation, the provider of MAC must be prepared and qualified to convert to general anesthesia when necessary. Additionally, a provider’s ability to intervene to rescue a patient’s airway from any sedation-induced compromise is a prerequisite to the qualifications to provide MAC.

The administration of sedatives, hypnotics, analgesics, as well as anesthetic drugs commonly used for the induction and maintenance of general anesthesia is often, but not always, a part of MAC. In some patients who may require only minimal sedation, MAC is often indicated because even small doses of these medications could precipitate adverse physiologic responses that would necessitate acute clinical interventions and resuscitation.

MAC also includes the performance of a pre-anesthesia evaluation and examination, prescription of the anesthesia care, administration of necessary oral or parenteral medications, and provision of indicated postoperative anesthesia care, i.e., assuring a return to full consciousness, relief of pain, management of adverse physiological responses or side effects from medications administered during the procedure, as well as the diagnosis and treatment of co-existing medical problems.

MAC affords the ability to adjust the sedation level from full consciousness to general anesthesia during the course of a procedure provides maximal flexibility in matching sedation level to patient needs and procedural requirements.

Sources:
https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
https://www.verywellhealth.com/monitored-anesthesia-care-explained-3157177
Modifiers 22 and 23

Modifier 22 - Increased procedural services

The term "increased procedural services" designates a service provided by a physician or other health care professional that is substantially greater than typically required for the procedure or service as defined in the Current Procedural Terminology (CPT®) book. Increased procedural services are reported by appending Modifier 22 to the usual procedure code, typical surgery CPT codes (10000-69999).

In order to be considered for additional reimbursement when reporting Modifier 22, most carriers require thorough medical records or reports and a separate document containing a concise statement about how the service differed from the usual service or procedure. The documents must indicate the substantial additional work performed and the reason for the additional work which may include, but not be limited to, increased intensity or time, technical difficulty of procedure that is not described by a more comprehensive procedure code, severity of the patient’s condition, or increased physical and mental effort required.

When properly applied and documented, modifier 22 ‘Increased procedural services’ allows a physician to receive greater reimbursement for an especially difficult or time-consuming procedure, approximately 20% increase.

Surgeon’s/Proceduralists may use modifier 22 with ICD codes to convey medical necessity for:
	- Trauma that significantly complicates the procedure and cannot be reported with any other procedure.
	- Significant scarring that requires extra time and work.
	- Morbid obesity that causes extra work for the physician (BMI >30, i.e., ICD E66.01)
	- Services that are significantly more complex than described by the CPT code.
	- Increased service intensity or procedural time
	- Increased technical difficulty, or physical and/or mental effort
	- An especially severe patient condition

For anesthesia, the use of modifier 22 is interpreted as difficulty with monitoring the patient’s airway, see Field Avoidance section of this Newsletter. (ALERT: 2019 recent changes - a News Blast will follow)

NOTE: MediCal allows specifically for field avoidance an additional 1 base unit for modifier 22. Other Insurance carriers only allow on ASA codes with base units of <5 and upgrade to 5 base units.

Modifier 23 - When medical necessity requires anesthesia for a surgery/service that usually does not require anesthesia

Modifier 23 when appended to a procedure is to indicate that as a result of unusual circumstances, a procedure that would normally require no anesthesia or local anesthesia must be performed under general or monitored anesthesia. Services submitted with Modifier 23 must be sufficiently documented in the medical records to establish the unusual circumstances that necessitate the use of general or monitored anesthesia on a procedure that normally does not require general or monitored anesthesia.

Modifier 23 is used only with general or monitored anesthesia codes (CPT codes 00100-01999).

Modifier 23 is added after the primary anesthesia modifier(s) which identifies whether the service was personally performed, medically directed or supervised (Modifiers AA, AD, QK, QS, QX, QY or QZ).

Sources:
https://www.aapc.com/blog/12472-append-22-to-unusually-difficult-procedures/
https://www.texmed.org/Template.aspx?id=22741
https://www.modahealth.com/pdfs/reimburse/RPM007.pdf
http://www.partnershiphp.org/Providers/Policies/Documents/Claims/Medi-Cal_Section%203.Subsection%20X.A.pdf
Separately Reportable Services *(if not billed with timed ASA code)*

Under certain circumstances, an anesthesia provider may separately report procedures that are not billed under an ASA timed code, if the documentation supports and the service is medically necessary.

Below are some examples of services that *may be* separately reportable if reported alone, i.e., not in conjunction with or on the same date as timed anesthesia services billed (as these codes are included in the timed anesthesia package).

IV start by a Doctor - the correct code depends on the patient's age and the IV location.

- 36000 (WRVU: 0.18) - Introduction of needle or intracatheter, vein
- 36400 (WRVU: 0.38) - Venipuncture, younger than age 3 years, necessitating the skill of a physician or other qualified health care professional, not to be used for routine venipuncture, femoral or jugular vein
- 36405 (WRVU: 0.31) - ...Scalp vein
- 36406 (WRVU: 0.18) - ...Other vein
- 36410 (WRVU: 0.18) - Venipuncture, age 3 years or older, necessitating the skill of a physician or other qualified health care professional (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture)

The current Medicare policy, which most carriers follow, says that venipuncture necessitating a physician's skill (36410) is defined as venipuncture on the veins of the neck, deep (central) veins of the thorax, or the groin.

The physician must puncture the vein at the time of specimen collection and have sufficient documentation to support the need for a physician's skill.

Sources:


2019 CPT code book


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adminservices@medtronsoftware.com