Purpose: Provide new FAA members the basic information for coding anesthesia cases and some basic rules for daily practice.

The FAA Billing Basics:
Anesthesia Intra-operative billing consists of 5 basic sources for billing units:
- **Base units:** units assigned by ASA based on the type of case
- **Time units:** 1 unit for every 15 minutes we spend with the patient
- **ASA classification:** units assigned based on patient’s health condition
- **Intra-operative procedures:** lines or pain procedures we perform in the OR
- **Post-operative pain services:** units for post-op pain care we provide

Your bill to the patient will be the summation of the above units multiplied by our agreed upon charge per unit. In 2008, our charge is $85/unit. Typically, any increased charge per unit is made as of January 1st and will apply for the whole year. Bills are submitted on “Green Cards” with an attached “Patient Face Sheet”. You need to provide all the pertinent information for the bill to the office; not limited to surgical procedure, diagnosis for surgery, surgeon, date of service, CPT anesthesia code, start & stop times, ASA status, and total charge to the patient, and anesthesiologist providing the care.

1. BASE UNITS
   Base units are “up front” units assigned to a case based on the perceived difficulty of providing anesthesia for the case. In general, the easier the case the fewer the base units (breast biopsy base of 3) and the harder the case the more the base units (open heart with circulatory arrest base of 25).

How do you determine the base units to assign to a case you’re anesthetizing?
   Every medical service and procedure performed by a physician is assigned a code determined by the American Medical Association. These codes are called CPT codes (current procedural terminology) and are listed in the CPT book put out by the AMA. Therefore, every procedure for which we provide anesthesia has a CPT code assigned to it. These procedures then have a corresponding typical anesthesia CPT code assigned to them. The conversion of a surgical CPT to the proper anesthesia CPT is called crosswalking the code. You can find all the procedural CPT’s converted to typical anesthesia CPT’s in the Crosswalk book put out each year by the ASA. The complete list of codes typically used by anesthesiologists is called the Relative Value Guide (RVG); the RVG is simply a condensed CPT book for anesthesiologists from the ASA. Most cases are easy to code and can be done based only on looking at the Relative Value Guide. The group condenses all our typical anesthesia codes to a single front-and-back page to make it easier to reference; but remember this is condensed and might not have a code you’re looking for if it’s for a procedure we don’t typically do.

To code a case, simply consider the area of the body that is having the procedure and look under the list of possible anesthesia codes. For example, your patient is having a shoulder arthroscopy with rotator cuff repair. The area is “Shoulder and Axilla” and you will see that 01630=Anesthesia for open or surgical arthroscopic procedures of the humeral head and neck, SC joint, AC joint, and shoulder joint, not otherwise specified. 01630 corresponds to a base of 5 units. You wouldn’t use 01622 since that is for a
simple **diagnostic** shoulder arthroscopy and only has a base of 4 units. As well, you wouldn’t use 01638 since that is for total shoulder replacement and has a base of 10 units. Incorrectly coding a procedure in order to get a higher number of base units is called **up-coding** and is considered fraudulent. Fraudulent coding can result in a Medicare Audit and penalties. FAA expects all members to provide accurate billing. We bill our own cases, and therefore, each member is expected to bill accurately. The billing office tries to catch any mistakes but each of us is ultimately responsible for our accurate coding. If you’re having trouble determining the proper code to use, another FAA member can help. Also, Ann, 202-1364 & 398-3356, has the CPT and Crosswalk books and can help.

**What do you do when multiple procedures are performed during one anesthetic?**

When there are multiple procedures performed, you need to determine the anesthesia CPT code and base units for each procedure. Determine which procedure has the highest number of base units assigned to it and use that as your primary surgical procedure. For example, a patient is getting a melanoma re-excised from his arm and a portacath placed at the same time. For the melanoma, you’ll look in the Arm section and see that it refers you to 00400 for all integumentary procedures on the arm=Anesthesia for procedures on the integumentary system on the extremities, anterior trunk and perineum= base of 3. For the portacath, you’ll look in the Intrathoracic section and see 00532=Anesthesia for access to the central venous system=base of 4. Therefore, on your billing card, you will list the portacath as the primary procedure and use 00532 as your anesthesia CPT billing code. You only bill the highest of the procedural codes(4>3); you don’t add the codes together and charge 7 units since this is fraudulent.

**What if the base units assigned to the case seem low compared to the work we did?**

If you disagree with the how an anesthesia code for a procedure is being crosswalked, you can submit a request to ASA for a change. But, until the change is made, you need to follow the presently assigned crosswalk.

ASA does allow an up-code to a base unit of 5 if the case is “around the head, neck, or shoulder girdle, requiring field avoidance, or any procedure requiring a position other than supine or lithotomy position.” This happens very rarely because most of those cases are already assigned a base of 5 or greater. But, for example, if a wrist fracture repair must be done per the surgeon’s request in the lateral position then the usual 01830=3 base can be up-coded to a base of 5. You must be sure to document on your anesthesia record the unusual position and also let the office know why you are up-coding the base units. They will need to explain it to the insurance company, so you have to give them enough information on the billing card to be able to justify it. Again, this will happen very rarely.

**2. TIME UNITS**

In addition to base units, we are allowed to bill 1 unit for every 15 minutes we spend providing care to a patient during a procedure. 7 minutes or less round down, 8 minutes or more round up to the next 15 minute increment. For example, if you spend 1 hour and 52 minutes with a patient, that is 7 intervals of 15 minutes plus 7 minutes. You should round down and charge 7 time units.
When does anesthesia time start and stop?

Anesthesia time starts when you assume control of the patient’s care for the procedure being performed. Typically, anesthesia time starts at the time the patient enters the operating room and you are in constant physical attendance with the patient. If you are delayed and enter the OR later than the patient, your start time begins when you enter the OR. Anesthesia time stops when you are no longer caring for the patient and have transferred that care to another person (i.e., the PACU RN). This time is typically when you leave the patient’s bedside in PACU. Typically, anesthesia stop time is within 10-15 minutes of surgical stop time. If this time is longer, there probably should be a reason cited in the record such as “extra time spent with patient managing laryngospasm.”

What about the time I spent in holding talking to the patient or helping push the patient’s bed into the OR?

A pre-op and post-op visit is required for all anesthetics and is included within the base unit charge already allowed for each case we do. Therefore, we can’t bill for time spent talking to the patient in the preop area. A nurse or orderly can roll the patient down the hall to the OR, so physicians aren’t allowed to bill for this time either.

If your patient has a severe anxiety disorder, requires a much larger than average pre-operative sedative, and is personally escorted to the OR by you so you can monitor their status during the transport, then you could start your anesthesia time at the time you administered the sedative. Again, this should be well documented in your record and is a very rare occurrence.

If you have a critically ill patient coming from the ER or ICU, you can start you anesthesia time at the moment that you assume care of the patient. This isn’t the time you start to review their chart. It is the time when you take over their care/their drips/their ventilation, and start personally moving them to the OR and managing any problems that occur during transport. But, most commonly, anesthesia start time should be the time the patient enters the OR.

How do I bill for non-continuous time with the patient?

You will very rarely have non-continuous time with your patient. Elective surgery at the Baptist Eye Institute (BEI) is one of the few times it may occur. At BEI, we are requested by the surgeon to provide sedation for their patient to have their eye surgery under block or topical anesthesia. We might sedate the patient and observe them for 15 minutes to ensure that they are stable and then turn over their continued care to a certified RN. Later, if the RN calls you back to the room to manage a problem, you can bill a 2nd start and stop time and add that to your total time units for the case. You can only bill for the time spent in constant physical attendance with the patient. The time intervals should be noted separately on your billing card but the total time units can be added. Remember, time intervals should never overlap with another patient, since we can’t be in two places at one time. Also, even though you can legally bill 8 minutes as one 15min interval, it is best if the next patient you bill is beyond the 15min limit of the previous patient.

Can I bill for time spent putting in lines (PA, Aline, Epidurals) outside the OR?

NO. The time required to place the lines or an epidural catheter is already included in the basic charge for the procedure (Aline 36620=3 units). At present, we
don’t deduct the time spent placing lines in the OR because “we’re proceeding with other surgical preparations” while placing lines (i.e. foley placement/prepping/counting).

3. ASA STATUS AND EMERGENCY MODIFIERS

Physical status of a patient per ASA is defined as follows:

<table>
<thead>
<tr>
<th>ASA</th>
<th>Description</th>
<th>Chargeable Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>normal healthy patient</td>
<td>0</td>
</tr>
<tr>
<td>2</td>
<td>patient with mild systemic disease</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>patient with severe systemic disease</td>
<td>1</td>
</tr>
<tr>
<td>4</td>
<td>patient with severe systemic disease that’s a constant threat to life</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>moribund patient, not expected to survive without the operation</td>
<td>3</td>
</tr>
<tr>
<td>6</td>
<td>brain-dead patient, organ harvest</td>
<td>0</td>
</tr>
<tr>
<td>E</td>
<td>emergency condition defined as existing when a delay in surgery would lead to a significant increase in threat to life or body part</td>
<td>2</td>
</tr>
</tbody>
</table>

ASA and emergency modifiers are charged by FAA and included in the total units that you generate. An exception is at BEI since a large majority of BEI patients are Medicare patients. Medicare doesn’t allow modifiers to be charged. Out of courtesy to the billing office and out of tradition, we don’t put modifier charges on billing cards from BEI patients if they have Medicare. See below for other BEI/L&D/GI alternate billings.

4. INTRA-OPERATIVE PROCEDURES THAT YOU CAN BILL

Certain intra-operative procedures performed by anesthesia are able to be billed in addition to the base and time units already assigned to a case. Aline, CVP, PA, TEE probe placement/monitoring, Ultrasound guidance, Epidural catheter, Intrathecal narcotic, and nerve block are possible to charge for if certain criteria are met.

Arterial access charges?

Arterial lines are charged as CPT 36620 with a unit charge of 3. It doesn’t matter which artery is accessed. On rare occasions, you may place a radial line and then later in the case need to place a femoral arterial line. As long as the 2 procedures were necessary and documentation in your record supports it, you can bill for both lines. You need to use a “separate and distinct” modifier of –59. For example, 36620 for the radial and 36620-59 for the femoral and put a note on the billing card as to why two of the same type of line were placed.

Intra-op ABG through a separate stick can also be billed under 36600 for 1 unit. You would only bill this if you needed to send a single ABG and didn’t plan on starting an Aline. Blood gases drawn through a previously existing Aline are not chargeable since they require little effort on our part.

Central Access?

A CVP is billed as 36556 for an adult for 4 units and PA catheter placement as 93503 for 10 units. Placing an introducer and floating a pulmonary artery catheter is
included in the 93503 for the total of 10 units. You don’t charge 4 for the introducer and then another 10 for the catheter.

Is there every a time where you could bill for 2 types of central accesss?
There are only 2 circumstances in which you would bill for a PA & CVP.
1. You actually placed 2 separate lines. For example, you need a PA but you also need additional IV access, so you stuck twice for 2 separate lines. This is a rare circumstance so you should make a note on your billing card so they know that there really were two lines and why. This way they can deal with the insurance company when they try to deny the claim. When you write the codes, bill the first normally PA 93503 and on the CVP add – 59 (i.e. 36556-59), which is a “separate and distinct” billing modifier.
2. You place a CVP for access and later that day (i.e. in the PACU), the patient decompensates and you need to float a PA (either through the CVP introducer or wire out a CVP line). Again, you should make a special note on the billing card as to why the CVP was converted to a PA and both are thereby chargeable.

The surgeon or their PA put some of the lines in to help the case start faster and told me to bill for it. Can I bill for those lines?
NO. Do not bill for lines placed by surgeons or their PAs (per group consensus). Sometimes the surgeon or their PA will help place lines in order to expedite the case. They can’t bill for these lines since any work they do is covered by a global surgical case fee. We shouldn’t bill for lines that we haven’t personally placed even if they offer to let us.

Transesophageal Echocardiography billing
You must, per group consensus, be credentialed by the hospital in TEE in order to submit TEE charges. For detailed information speak with the Chief of Anesthesia, but in general, credentially requires that 10 TEE exams be proctured and approved by a credentialed group member. It is not necessary to be certified by the American board of Echocardiography in order to be credentialed by the hospital.

If a credentialed FAA member deems intra-op TEE to be necessary for a case, there are 2 group approved chargeable CPT codes. 93318=TEE for monitoring purposes, including probe placement, real-time image acquisition & interpretation leading to ongoing assessment of heart function and therapeutic measures based on the echo. This is a 6 unit charge and should be substantiated by recording images on the echo platform and documentation in the anesthetic record of pertinent intra-op echo events and subsequent therapies done based on echo findings. If you place the TEE probe but do less than the above mentioned evaluation, then you should bill it as 93313 for probe placement only and a 2 unit charge.

Ultrasound was used to place the lines or a block. Can this be charged?
At present, ultrasound guided placement of vascular catheters is charged for using “add-on” code 76937 for a 1 unit charge. Typically, you will employ ultrasound guidance in anti-coagulated, morbidly obese, or prior neck surgery patients. If you
charge 76937, then you must document evaluation of vessel patency, visualization of needle entry into the vessel, and permanent recording and reporting of the procedure. At present, ultrasound guided block placement is not able to be charged.

5. Post-operative pain procedures

You can only bill for procedures done for post operative pain if they are separate and distinct from your primary anesthetic. For example, you are doing a total knee under general anesthesia and also decide to place a femoral nerve block for post-operative pain control. In this instance, the femoral nerve block is separate and distinct and is billed as 64447 as 7 units. You should write a procedure note in your record, write orders addressing the patient’s plan for appropriate pain control for the next 24 hours, round on the patient the next day, and write a post-procedural note the next day.

Another example would be an epidural catheter placed for a thoracotomy. A thoracic epidural catheter use code 62318=10 units and lumbar use code 62319=9 units. This is a large unit charge. You should write a procedure note, fill out the epidural orders, be reachable by beeper as long as the catheter is in place, and round and write notes on the patient daily. The 1st 24 hours of follow-up is covered by the large up front fee and subsequent 24 hour intervals are covered under E&M charges (see pain info).

Intrathecal narcotics administered at the time of the primary spinal anesthesia for a cesarean section or total joint is not separate and distinct. You cannot bill 62311 for a total of 8 units; this would not be reasonable per group consensus. You can charge for the 24 hours of post-operative pain care though with the proper E&M code.

Look at the separate information on pain billing for further details.

6. LABOR AND DELIVERY BILLING OF THE PATIENT

This section covers how to bill a patient in L&D. The group reimburses individual members for their L&D work under a modified system delineated in another section.

**Labor epidurals:** bill using code 01967=base of 5 plus one unit of for each 15min time interval. The start time is when you enter the patient’s room (the labor nurse puts this time in her electronic chart) and end time is placenta delivery time in FAA practice.

**Patient with labor epidural that delivers via csection:** Bill the initial labor epidural as above with 01967. The ending time for the labor epidural is the time that the patient goes to the OR. The OR time is billed using 01968=base of 3 plus one unit for each 15 min time interval. Csection end time is billed as with any OR case, when you transfer care of the patient to the PACU nurse. Don’t forget to add an ASA Emergency code for 2 additional units if it is indicated.

**Cesarean section anesthesia only:** For the patient undergoing csection with no prior epidural placement, you use 01961 with a base of 7 units and one unit for each subsequent 15 minutes. Don’t forget to add an ASA Emergency code for 2 additional units if it is indicated.

**Csection + hysterectomy:** With a prior epidural for labor, you code this by adding on 01969 for a base of 5 instead of using 01968. If there is no prior epidural, use only 01963 for a base of 10.

**Post partum tubals:** Use 00851 with a base of 6 units. If the OB CRNA helps provide the anesthesia, be to meet Medicare standards and document your presence during the “key points of the anesthetic.”
**Dilation & Curretage:** We will occasionally provide anesthesia on OB for D&C’s. Remember that there are separate codes for D&C for spontaneous missed or incomplete abortion(01965=4+time) and induced abortion for fetal anomaly(01966=4+time). There are no elective abortions performed at Baptist.

7. **MONTHLY BILLING SHOULD BE SUBMITTED TO THE OFFICE WHEN IT IS COMPLETED. ALL BILLING SHOULD BE SUBMITTED TO THE BILLING OFFICE NO LATER THAN THE 15TH OF THE FOLLOWING MONTH.**

8. **REIMBURSEMENT FOR UNITS BILLED**

   Typically, the group reimburses individuals for work done based on the percentage of total units the individual generates in comparison to the total units generated by the group in the same time period. We typically get paid once a month and our paid for a month’s work 2 months after the work has occurred. See contract for more specific details.

**Splitting case reimbursement**

   When more than one anesthesiologist is involved in a patient’s care, the units for the case are credited to each anesthesiologist based upon the percentage of total anesthetic time each physician spent with the patient. The bill to the patient will be generated by the 1st physician involved in the patient’s care. Subsequent physicians should make a note of the time they were present on the patient’s facesheet and put it in the original physician’s office box. The billing office will compute the “split fee.” Fees on Labor & Delivery are split differently, see below.

**Modified reimbursement units:**

   In certain instances, the group has agreed that the units generated by a particular type of anesthesia need to be modified in the way they are reimbursed. This modified reimbursement may change over time and is subject to the vote of the group.

**Labor & Delivery**—Charges on L&D are submitted to the office as previously delineated, but individuals will be reimbursed from L&D by the group using a modified billing unit. Per group consensus 3/08 meeting, the maximum an individual will be reimbursed for a labor epidural ending in a vaginal delivery is 16 units. So, if the labor epidural results in a 22 unit charge, you should charge 22 units to the patient but realize that you will only receive a max of 16 units credit from the group. If the labor epidural generates 12 units, the patient will receive a bill for 12 units and you will receive credit for 12 units. Labor epidural that go to csection should be charged as previously delineated but have a maximum modified unit charge of 24 units.

   On labor and delivery, if two physicians are involved in a patient’s care, we split the whole patient charge 50/50. So, if Doctor A puts in the labor epidural at 3am but Doctor B provides anesthetic care for the Csection for failure to progress at 6 pm, the total patient charge is split 50/50. For labor to section, the split in this case would be 50% of 24 units, or 12 units each. If Doctor B provides
neuroaxial narcotics, this should be charged and billed by Doctor B in the standard way with no split.

If a labor epidural carries over from one shift to the next, the physician who placed the epidural gets the full charge unless the catheter needs to be replaced by the 2nd MD. A face sheet for the still laboring patient should be left by the 1st physician on the epidural cart. The time of placental delivery and any need for catheter replacement should be noted on the facesheet and the sheet returned to the 1st MD’s box. Epidural catheter replacements are not often needed but if they do occur, the 2 MD’s split the 16 unit maximum equally.

Baptist Eye institute charges and group reimbursement

a). Regular Day assignment to Eye Institute:
The day’s time starts when you start taking care of your first patient and ends when the last patient leaves the OR (per the RN’s record). You bill every case with your green billing card as usual, except that at BEI we don’t charge modifiers (i.e. ASA status or E) on Medicare and Medicaid patients (since they don’t pay modifiers). You typically bill 15 minutes for blocking or sedating the patient; don’t let your times overlap. If you later are called to the room to manage a problem or later go and sit a case (i.e. the last case of the day), you can bill that non-continuous time as well. Submit your green cards and a copy of the last computer generated RN OR records to Ann and you will be compensated 8 units per hour that you were there that day. (So, like OB, what you bill may be very different from what the group has agreed to give you credit for as a BEI day).

b). BEI Emergency cases when you are called back greater than 2 hours after last case for add-on/emergency or you are the 2nd MD at BEI assigned for a General Anesthesia case:
You submit a regular bill (like anywhere else) and will be compensated based on that bill. (For these cases, the 8 units/hr rule doesn’t apply).

Gastroenterology Laboratory cases
Per group consensus at 3/08 meeting, all GI lab cases are billed according to the usual rules. But, any case other than an ERCP or Double Balloon Enteroscopy, will be reimbursed to the individual at a reduced base unit amount. Usually, GI cases have a base unit of 5 but the group will reimburse at a base of 3. ERCP/Double Balloons usually require a general anesthetic and significantly more work which is why we still reimburse ourselves a base of 5 units for these cases.

9. What do I if I have to cancel a case?
-Pre-op cancellation-If you simply cancel a case in preop holding, it is not typically billable. If the patient has a problem preop and you order drugs (i.e. for bronchospasm or severe hypertension) and manage their care, call other MDs (i.e. cardiology) for consultation, or personally coordinate their follow-up, you could bill an Evaluation and Management code based on the amount of work involved. For an inpatient, see
inpatient consults below. For an outpatient, the E&M codes are 99241-99245 and you need to dictate the consult done and give a diagnosis for why the consult was needed. Determine the level of the consult based on the work involved. E&M's are looked at very carefully by Medicare for fraud, so be sure you only bill for what you can prove you did. It is very rare we would ever bill a level 4 or 5 evaluation because you’d have to do a multi-organ detailed exam to justify it.

- 99241 Problem focused Hx/exam & straightforward decisions typically 15 minutes face-to-face, 2 units
- 99242 Expanded problem focused Hx/exam & straightforward decisions, typically 30 minutes face-to-face, 4 units
- 99243 Detailed Hx/exam & decision of low complexity typically 40 minutes face-to-face, 5 units
- 99244 Comprehensive Hx/exam & moderate complexity decisions, typically 60 minutes face-to-face, 7 units
- 99245 Comprehensive Hx/exam & high complexity decisions, typically 80 minutes face-to-face, 8 units

-Intra-op cancellation-If you take a patient into the OR and then have to cancel the case for any reason, you can bill for time spent with the patient plus the base units for the surgery you would have been performing. On your card state the reason the case was cancelled such as patient condition/contraindication(v64.1, i.e. arrythmia, bronchospasm, aspiration), patient decision(v64.2), or other(v64.3, i.e. equipment failure).

10. Pre-operative Consultations:
Our standard anesthesia pre-op is not billable since this service is included in our base units paid for each case.

In unusual circumstances and by meeting strict criteria below this can be billable.

1) “Pre-operative Anesthesia Consultation” must be requested/ordered by surgeon.
2) The consultation must be “medically necessary”, such as extreme medical condition requiring our input into how to optimize the patient and help determine their operative risk.
3) You must give ICD-9 diagnosis codes that support the medical necessity of the consult(i.e. Afib/unstable angina) and give the additional preoperative services code(v72.81=preop cardiovascular exam, v72.82=preop respiratory exam, v72.83=other specified preop exam, v72.84=preop exam, unspecified).
4) Document why this is different from the usual preop evaluation. You should write the consult on a consult sheet or progress notes, dictate the consult, and bill the right E&M code plus ICD-9 code. If the consult was on a outpatient use 99241-99245(see above, #7) or use 99251-99255 consults on in-patients(see below).
Again, determine the level of the consult based on the work involved. E&M’s are looked at very carefully by Medicare for fraud, so be sure you only bill for what you can prove you did (see section 8 above). It is very rare we would ever bill a level 4 or 5 evaluation because you’d have to do a multi-organ detailed exam to justify it.

11. The OR schedule

- It is typically assigned by 2nd call the night before based on case, ending times, pecking order (the most up to date rules will be on schedule clipboard).
- Going home - lowest person on the pecking order goes home 1st, and so forth.
- Refusal of relief - On certain cases (hearts/ personal request case), you can turn down relief if you wish but once the case is done you will then have to go home. Occasionally, you may be dealing with a very unstable patient and the relieving physician may, in consultation with you, decide not to relieve you in order to optimize patient care. If offered relief on any other case and you have more than 20-30 minutes till the case ends, you must take relief. If you wish to work longer, you can ask to move up in the pecking order and see if anyone above you is interested in moving down to your spot.
- You don’t get a schedule - if you’re on the pecking order but so low that you don’t get a schedule, you must still remain available for add-ons or emergencies till 9 am that day.
- Preops - All patients who are in the hospital the night before surgery are to receive a pre-operative anesthetic visit, appropriate testing, consent for anesthesia, and any needed pre-operative medication ordered.
  - Downtown, in house preops are done by OB call and assisted by MD’s in the main and pavilion OR’s. If the ending time on your last case is after 5 pm, you need to ask the front desk for an in-house pre-op to see. OB, 1st, 2nd, and 3rd (if 3rd finishes post 5 pm) are required to stay until all pre-ops are seen.
  - Baptist South - the OB anesthesiologist is responsible for coming to the OR desk around 5 pm to check that the next day’s schedule is appropriately assigned. OB anesthesia also needs to see all the in house preops at South.
- JOI and BEI - you are done when your schedule is done and don’t need to go back to the main OR. If your schedule at JOI finishes earlier than expected,
you should relieve others at JOI who are lower in the pecking order.
-Post op rounds-we have several PACU RN’s hired to see our post op patients.
-Pain service-you should see and charge your own post-op visits on acute pain patients(epidurals/intrathecals). If you are on vacation/weekend/post-call and therefore are not working, call Ann or call the person on OB directly to see your patient. They will put a note about the patient on the OB epidural cart if you need to patient to be seen for more than 1 day. OB call will see the patient and bill for those days. You only bill for the days you personally saw the patient.(Per group decision 2/04).
Downtown, we have a Baptist RN pain education coordinator who is responsible for educating the RN’s on proper care of pain patients. At present, this is Lori Overstreet and she can be reached at 202 4106 or urgently at beeper 889 0138. If you are having an emergency with your patient, you can have the operator connect you to her or call OB anesthesia(x 22055).

Pacemakers & AICD’s-as a group, any patient with these devices who was exposed intraop to electrocautery is getting a post op evaluation by the device’s representative to verify proper functioning. PACE should get the patient’s pacer/AICD card so you can call the manufacturer to determine how to send the pacer into asynchronous mode prn and/or disable the AICD intraop. For the post op check, simply call PACU during the surgical case and tell them which rep needs to be contacted and they will coordinate the check. I usually write an order in the chart that the patient must stay on telemetry until proper function has been determined by the rep(CYA).