

# Executive Director's Page

## What if Time Went Away?

*By Barbara Baldwin, CSA Executive Director*

**I**n the world of claims processing, anesthesia billing is different from all other. The time element, although simple in concept, has confused and confounded many billers and payers alike. As payers increasingly seek standardization and simplification of billing and reimbursement, the anesthesia payment methodology has come under scrutiny and, some might say, attack.

The ASA-created Relative Value Guide for anesthesia services currently is accepted by nearly all payers as the standard. But now the 600-pound gorilla, the Centers for Medicare and Medicaid (CMS) and the RUC (Relative Value Update Committee) are citing the different payment methodology as an obstacle to correcting the undervaluation of the work component that has been in place since the inception of RBRVS. The ASA appointed a special committee, the Task Force to Study Payment Methodology, to review and evaluate the advantages and disadvantages of adopting one of four different payment methodologies. See Dr. Sullivan's ASA board report on pages 28-29 for more information.

Over the past year, the task force has provided progress reports to the ASA board and submitted three additional reports to the House of Delegates. The task force's reports are the single topic of discussion for one reference committee at the upcoming ASA Annual Meeting on October 24. Knowing that the topic is extremely controversial, the reference committee will be held before the others so that all delegates can participate in the hearing.

The ASA's primary focus in exploring new coding methodologies is to correct the significant undervaluation of anesthesia services in the RBRVS. Thus far, the ASA has had very limited success in obtaining overall increases in anesthesia payments. After going through two five-year code review cycles, the ASA achieved a 22.76 percent increase in the anesthesia work value in the first and none in the second. The 22.76 percent increase translated to an overall adjustment to the conversion factor of 9.2 percent in 1997. As is typical in political environments, the merits of the issue do not determine the outcome, but the economy and political considerations do.

As the third five-year review approaches, other possible ways of achieving parity are being explored. The ASA is proceeding on an urgent basis in anticipation that the scheduled reductions in all physician payments beginning 2006 will, in fact, take place. If a correction is not in the works before a reduction is implemented, anesthesia payments may drop to Medi-Cal levels, and eventually below.

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### **Alternative Payment Methodologies**

As currently structured, anesthesia codes cannot be incorporated into the RBRVS; the square peg in a round hole analogy applies here. The Task Force developed and evaluated four alternative coding methodologies that might enable a fair transition to RBRVS. These include: 1. Flat fees based on an expanded anesthesia code set; 2. Time-based using the existing or an expanded anesthesia code set; 3. Flat fees based on surgical CPT codes (the old California Relative Value Studies method); 4. A building block model that includes evaluation and management codes, and pre- and post-operative time plus value for intraservice time. This may be viewed as an a la carte approach.

Evaluation criteria for determining feasibility included consistency with RBRVS methodology, methods of incorporating time, complexity of code development and implementation, consideration of multiple surgical procedures, methods of addressing undervaluation in the Medicare Fee Schedule, and impact on various types of anesthesia practices. The Task Force determined that Option One was the only viable possibility based on application of all the criteria.

In order to develop a broader code set, the Task Force took five anesthesia codes, each of which covers 75-126 surgical codes and expanded them to flat-fee anesthesia codes. Additionally, the surgical codes were grouped so that work effort for each is similar. From this exercise, the Task Force estimates that 1,200-1,500 anesthesia codes would be necessary to make a flat-fee system feasible. In order for this methodology to be valid, a database of anesthesia times from both academic and private practices would have to be updated continually.

Several critical considerations emerged as the committee began its work. Factors such as the impact on academic institutions, and accounting for prolonged anesthesia services and multiple surgical procedures prove to be significant complicating factors. At this time the Task Force is working on expanding the code set and compiling payment data in the private sector.

On Saturday, October 24, the ASA House of Delegates will consider this resolution:

RESOLVED, That the Executive Committee in consultation with the Administrative Council is authorized to propose a restructuring of Medicare payments for anesthesia services based on the following principles:

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1. That any new coding system must accurately reflect both the complexity and duration of the associated surgical procedures to compensate for the elimination of separately reported anesthesia time;
2. That the inevitable influence of a uniform Medicare conversion factor on payment rates in the private sector be thoroughly considered; and
3. That any transition to a uniform Medicare conversion factor must be based on a value sufficient to protect the specialty, as a whole and in aggregate, from economic damage.

In addition to the issue of changing the anesthesia coding system, it is certain that a lively debate will ensue as to whether the ASA Executive Committee and Administrative Council should have decision making authority to move forward in the absence of Board and House of Delegates review.

The prospect of changing the payment methodology for anesthesia services has far-reaching implications. Any new code set would soon be adopted by other payers, particularly if it simplified their work. If some correction for the undervaluation of work was not applied in the changeover, anesthesiologists would be severely jeopardized financially. Since private payers are negotiating reimbursement rates as a percentage of Medicare rates, continued underpayment would eventually result in a crisis for the specialty. Not good news, but a dose of harsh reality.

### **CSA Pain Management and End-of-Life Care Educational Program**

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