Executive Director's Page

Medicare 2005

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This is the time of year to prepare for changes in Medicare rates, procedure codes and policy. The good news is that physicians will receive a 1.5 percent increase in reimbursement as mandated by Congress. Although the five-year review of anesthesia services did not result in significant adjustments, this small adjustment goes in the right direction.

The 2005 Medicare Physician Fee Schedule and supporting material was published in the Code of Federal Regulations (CFR) November 15, 2004. Those interested in accessing the 600+ page document can access it by going to the 2004 listing of federal regulations at **http://www.access.gpo.gov/su_docs/fedreg/frcont04.html**. Click on the November 15, 2004, link and open the Physician Fee Schedule (2005 CY); payment policies and relative value units adjustment, pages 66235–66915.

More applicable to California, however, are the fee schedules for each of the nine geographic regions. National Heritage Insurance Company (NHIC) began sending fee schedules and provider applications to all enrolled Medicare providers on CD-ROMs late last year. By now you should have yours in hand. Alternatively, fee schedules can be downloaded in their entirety from the NHIC web site at **http://www.medicarenhic.com/cal_prov/fee_sched.shtml#2**.

The California anesthesia conversion factors for 2005 are:

2005 Anesthesia Conversion Factors–California				
Loc	**California Counties**	**Provider**	**Non-Provider**	**Non-Provider Limit**
03	Marin, Napa, Solano Counties	$18.27	$17.36	$19.96
05	San Francisco County	$19.30	$18.34	$21.09
06	San Mateo County	$19.20	$18.24	$20.98
07	Alameda, Contra Costa Counties	$18.61	$17.68	$20.33
09	Santa Clara County	$19.25	$18.29	$21.03
17	Ventura County	$18.11	$17.20	$19.79
18	Los Angeles County	$18.72	$17.78	$20.45

26	Orange County	$18.68	$17.75	$20.41
99	Rest of California	$17.55	$16.67	$19.17

There are few revisions to the ASA RVG for 2005. The only new anesthesia code is 00561–Anesthesia for procedures on heart, pericardial sac, and great vessels of chest; with pump oxygenator, under one year of age. This new code has 25 base units. Three codes in the CPT sometimes used by anesthesiologists have been modified. Payment from Medicare is determined by the Medicare Fee Schedule and not the ASA suggested units.

Code	Descriptor	ASA suggested units
63685	Insertion or replacement ~~Incision and subcutaneous placement~~ of spinal neurostimulator pulse generator or receiver, direct or inductive coupling	23
94060	Bronchodilation responsiveness, ~~Bronchospasm evaluation;~~ spirometry as in 94010, pre and post ~~before and after~~ brochodilator administration ~~(aerosol or parenteral)~~	10
95971	Electronic analysis of implanted neurostimulator pulse generator system …; simple ~~brain~~ spinal cord, or peripheral … neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming	3

Policy Issues Update

The CSA and ASA have raised issues about anesthesia practice which the ASA has been working on for the past year with the Centers for Medicare and Medicaid Services (CMS). Questions are forwarded to the PRIT–Physician Regulatory Issues Team–who, with information from the ASA, clarify national policy. Three issues are currently under consideration and final determinations are expected soon.

Questions on post anesthesia reports have been circulating for some time. Current CMS policy, with respect to inpatients, is unclear as to whether a different anesthesiologist (who did not administer the anesthesia) may perform the post anesthesia recovery unit evaluation and report. This issue involves the Medicare Hospital Conditions of Participation. The CMS' Office of Clinical Standards and Quality is actively reviewing this issue as well as others in the Conditions of

Participation. The question will be resolved in the soon-to-be-released Hospitals Conditions of Participation.

Another issue plaguing anesthesiologists concerns security of anesthesia carts. Currently, CMS requirements exceed JCAHO and some state survey certification requirements. This issue was brought to the PRIT by the ASA May 10, 2004, and will be resolved in the soon-to-be-released Hospitals Conditions of Participation.

The third issue being addressed is a billing issue. Some anesthesiologists feel clarification is needed in how to bill appropriately for a case which is started by a supervised anesthetist and completed by the supervising anesthesiologist.

The PRIT has a proposed resolution acceptable to the ASA. The AANA and the ASA have met together to discuss this issue, and at this time internal review is proceeding favorably and a decision is expected in the near future.

On the local front, NHIC has issued a change in its local policy on implantable infusion devices for chronic intractable pain. Although the new policy was first published October 29, 2004, the changes are effective January 1, 2004. Changes include new instructions on the pricing of drugs infused by implantable infusion pumps per CR 3022 and CR 3105 and update the Local Coverage Determination (LCD) language.

The policy is accessible on the NHIC web site at **http://www.medicarenhic.com/cal_prov/lmrp/lcd_00_122R1.htm**

Available Resources

Many physicians and their billers are not aware of useful information on Medicare coverage policy and billing developed by CMS and NHIC. These manuals can answer many questions routinely raised among providers. Some billers also have been successful in reversing or modifying denials based on information in these documents.

The federal manual is the *CMS Medicare Information for Anesthesiologists*. This 178-page document can be downloaded from the CMS web site at **http://www.cms.hhs.gov/physicians/anesthesiologist/default.asp**.

The local resource published by NHIC is its Anesthesia Billing Guide which was updated in August 2004. It is available at **http://www.medicarenhic.com/cal_prov/lmrp/lcd_00_122R1.htm**.