Anesthesia Reimbursement

Should it Be Changed to a Non-Time Based System?

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During the ASA Annual Meeting in New Orleans last month, the issue of reimbursement methods for anesthesia services was discussed. Data and arguments for a possible change from our current base-plus-time based system to a flat-fee, non-time based system were heard by a special reference committee and the House of Delegates. The final decision on the matter was to refer to a task force to continue studies and to report next year. In this brief article, I will describe the rationale for considering the question at all and the arguments pro and con. I am purposely over-simplifying a very complex subject to make it understandable in less than 1,500 words.

It is important to understand that the issue refers only to Medicare services. However, as we all know, commercial insurers tend to follow the lead of Medicare in setting up and negotiating reimbursement schemes and rates.

Issues

1. Our current services are undervalued by Medicare.

When the Medicare Fee Schedule (MFS) was revised in 1992, our rate of reimbursement was severely reduced in contrast to the rest of medicine. The Hsaio study recommended reductions in our rates due to evidence that our work component was overvalued. Our rate of reimbursement was reduced 29 percent (from $19.27 to $13.68) at that time. Attempts to reverse this reduction have been relatively unsuccessful.

Evidence to show how our reimbursement compares to the rest of medicine are based on the fact that Medicare anesthesia services are currently paid at 34 percent of the rates paid by commercial insurance payers. This compares poorly to the rest of medicine, which is paid by Medicare at 78 percent of the rates paid by commercial insurance payers. This either says that anesthesia services are underpaid by Medicare or overpaid by commercial payers. I doubt that anyone would say that we are overpaid by commercial insurers.

The current Medicare Anesthesia Conversion Factor (CF) is $17.05, compared to a CF of $36.77 for Medicare services for the rest of medicine. These are national averages. This cannot be directly compared because our system of

reimbursement is based on a base-plus-time system of reimbursement that is based on the ASA's Relative Value Guide (RVG) fee schedule and the rest of medicine is paid by a flat-fee or global system based on the Resource-Based Relative Value System (RBRVS) fee schedule.

2. Reluctance of the RUC to recommend increases in Anesthesia reimbursement

The AMA Specialty Society Relative Value Update Committee (RUC) has been given power by the Centers for Medicare and Medicaid Services (CMS–and formerly known as HCFA) to recommend updates to CMS for changes in physician reimbursement. The ASA has representatives on this committee. However, since anesthesia is the only specialty to use a time-based reimbursement system, we are treated differently by the rest of the members of the RUC. In fact, it is fair to say that they ignore our arguments that we are underpaid by saying that they just do not understand our time-based system (and don't want to take the time to figure it out.) Because of our "outsider" status, we have been basically unsuccessful with any attempt to change the current inequity. Members of the RUC have told our representatives that we will have to abandon our time-based system before we will be taken seriously.

The RUC makes recommendations to CMS every five years and the vast majority of them are accepted by CMS. A five-year review (the second) was recently completed. After extensive review and discussion about compensation for anesthesia services, the RUC did not recommend any change to CMS. CMS resolved the issue itself by granting a 1.6 percent payment increase for anesthesia services in 2003. In 2005, anesthesiologists along with all other physicians will receive a 1.5 percent statutory increase. The next five-year review process will begin in 2005. The ASA representatives to CMS and to the RUC will continue to argue that anesthesia fees are undervalued relative to other specialists and attempt to use the RUC system to improve compensation. If that is unsuccessful, the ASA may have to seek legislative (Congressional) intervention.

It is also important to understand that any changes have to be made in a "zero-sum game." In other words, there is a pot of money which will not get any bigger. So, if we are given an increase, it has to come out of another specialty's pocket.

3. Medicare influence on private payer rates

Currently, many payers negotiate rates by a percentage of Medicare rates (most often 120 percent of Medicare CF). For most physicians (excluding anesthesiologists) this is a pretty good deal since 120 percent of the CF for non-anesthesiologist physicians is 120 percent times $37 equals $44, very close to non-anesthesiology commercial rates. However, for anesthesia, 120 percent times $17 equals $20, nowhere close to the 2003 commercial average rate for the United States of $50. Once again, our different payment system penalizes us in negotiations with commercial payers when we must argue that we cannot take the same percent of Medicare that everyone else does.

In some ways, the fact that we are different helps us now, in that we can reject the commercial rate proposal for 120 percent of Medicare rates outright with good justification.

4. Would integration into RBRVS with a flat-fee based system of reimbursement help or hurt us over the long and short term?

The answer to this question is so complex that it is not answerable at this time. On the one hand, if we were part of the rest of the house of medicine, the RUC would treat us like everyone else. The problem is the transition to a flat-fee RBRVS system. If the new system could be structured to make the transition for the average anesthesiologist a "zero-sum game," then we would do as well as medicine overall over the long term. On the other hand, there would be winners and losers across the anesthesia community, especially if the transition was not structured correctly.

5. How could we structure the change to make it a zero-sum game for everyone?

Here is what it would take: Our CF would have to be increased to the same as the rest of medicine ($37). Of course, we would need to bill fewer units per case (flat-fee) so that the final bill was the same as it would be under the current time- based system. This truly would be a zero-sum game for us and for CMS. Then, when a payer said, "We will give you what we give everyone else, 120 percent of Medicare," we could say OK because we would now be close to our current Commercial rate.

6. What would a final flat-fee system look like?

First, our current ASA's RVG with its 270 codes would not work. This fee schedule is just not detailed (granular) enough to capture complex cases that would take longer than simple cases. We need a much more "granular" fee schedule with perhaps 1,500 to 4,000 different codes in it, similar to the Relative Value System (RVS) that surgeons now use. We would also have to mirror the surgeon's practice of billing for multiple procedures and finding the code that best matched the complexity of the surgical procedure. Remember, we no longer would have a time component, but rather a global or flat fee based on the number of units allowed for the procedure.

7. Who would winners and losers be?

Certainly, the best example of a loser would be academic teaching centers. The combination of high Medicare loads, complex cases lasting longer, and the time burden of teaching would mean that academic centers would immediately lose a significant part of their income under a flat-fee, non-time based system. You might say, Medicare can just give teaching centers a "kicker" to make them whole. Well, that will not happen for anesthesia reimbursement because no other specialty has a surcharge granted for teaching.

Winners might be a private practice with non-complex cases and fast surgeons. A flat fee based on average times would be good income for this sort of practice.

8. Are we actually going to do this?

At this time, the decision of the ASA is to continue to study the problem. Many feel that we should consider developing a new Anesthesia RVS that would work with a flat-fee system. We also need to gather data on the average time of cases so that the proper number of units is given to a flat-fee RVS procedure. At this time, our time based system seems to be working fairly well for the specialty. Over the long run, however, this may not be the case. We need to continue to study this issue so that our specialty can be prepared to transition to a flat-fee, non-time based system **if and when** circumstances require it.

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