

ANESTHESIA SERVICES REIMBURSEMENT

UNDER MEDICARE PART B
Preliminary Review and
Study Design Considerations

Prepared Under

Contract No. HCFA 500-84-0036

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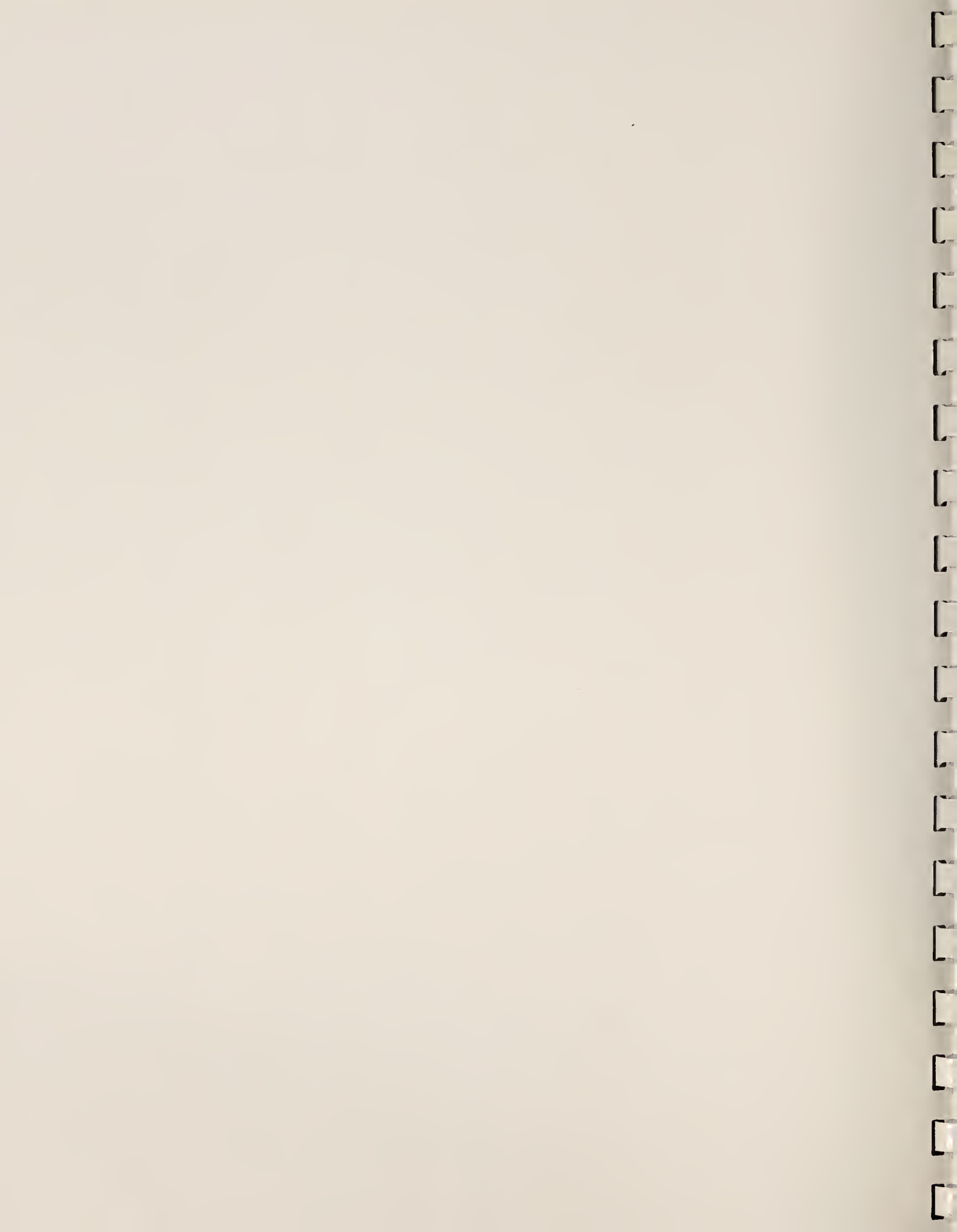
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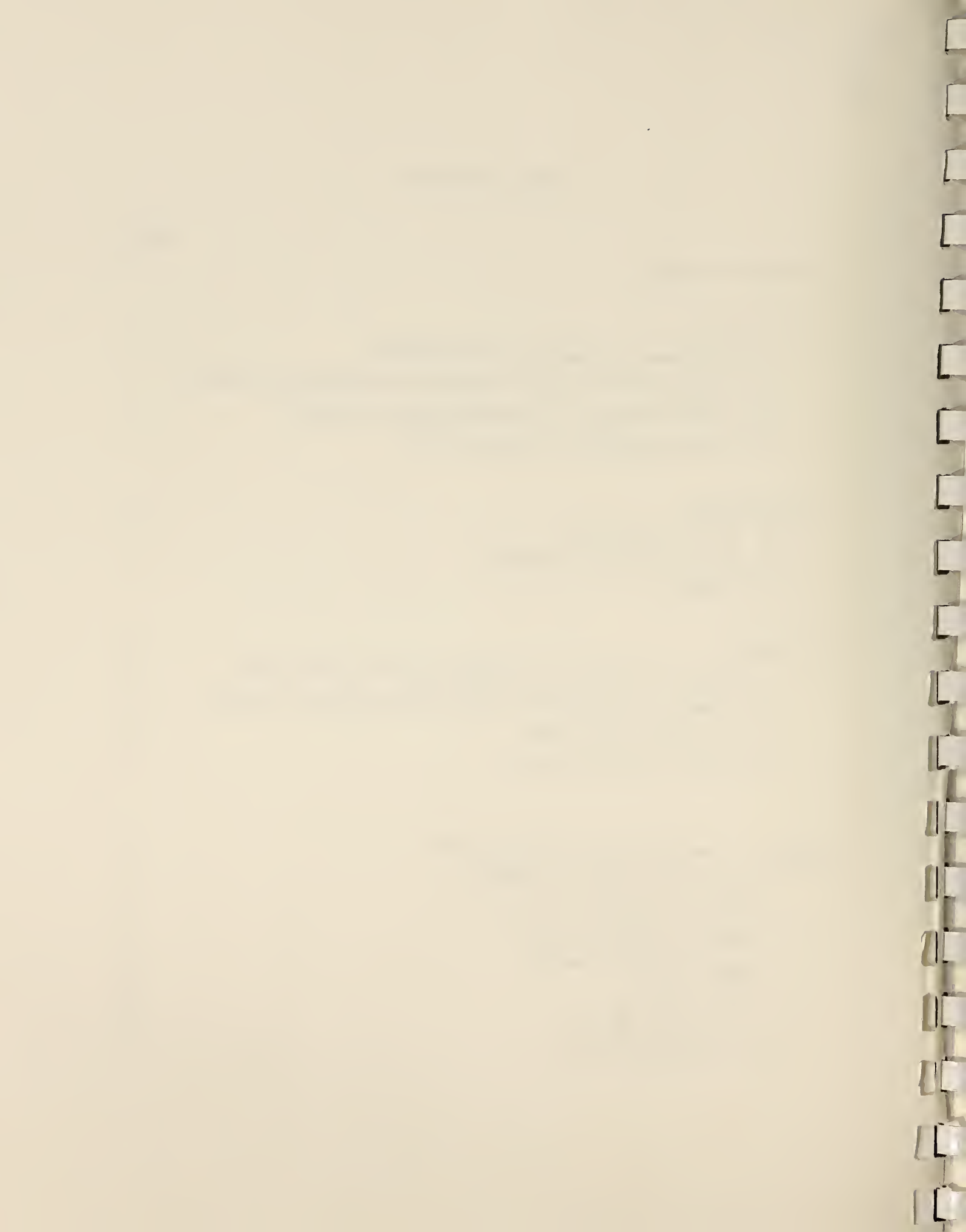
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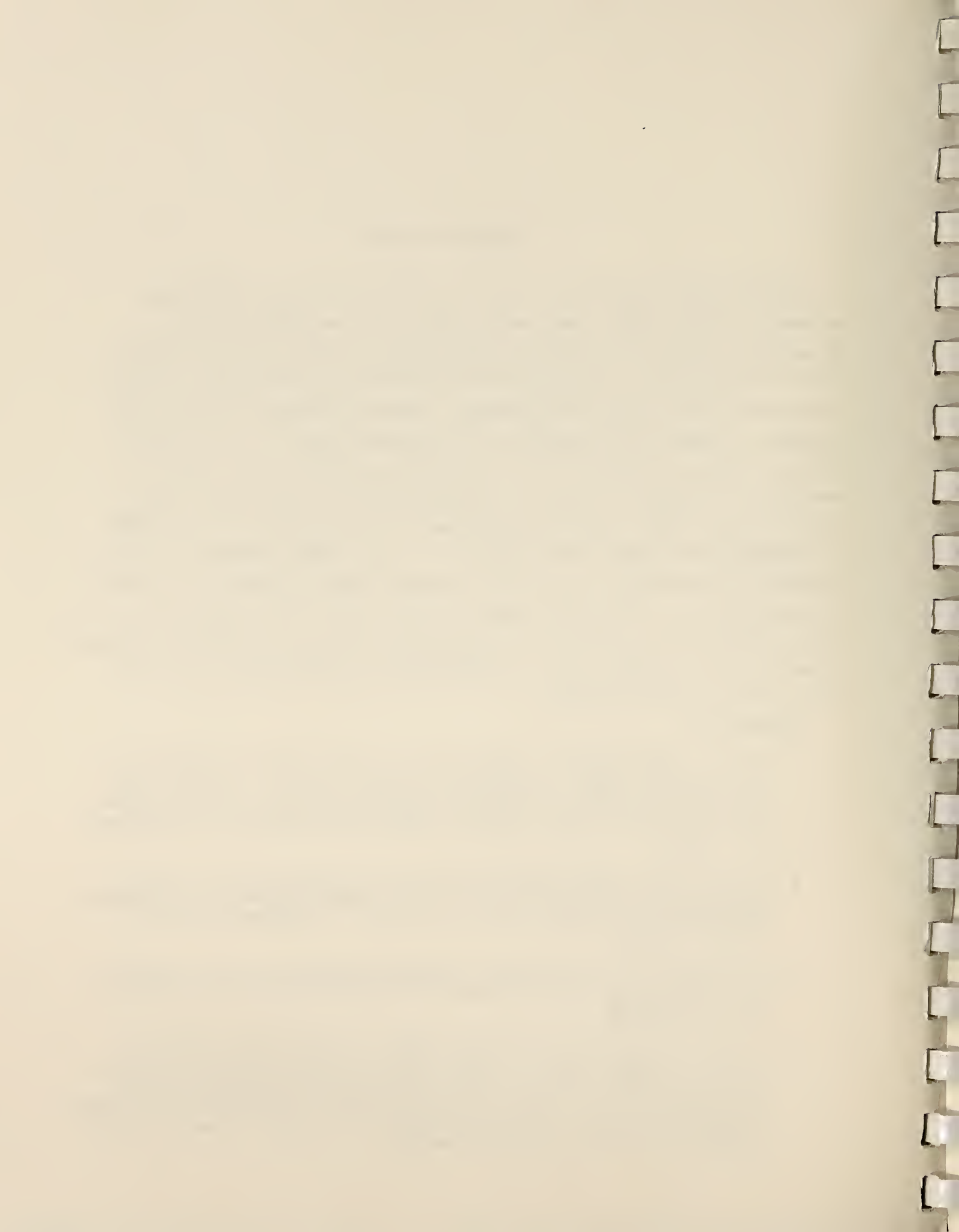


1. EXECUTIVE SUMMARY

Reimbursement under Medicare Part B is based on the use of HCPCS which includes all current CPT-4 codes except those in the anesthesia section. The anesthesia codes and guidelines which appear in current versions of CPT-4 are not used because of concerns that such use would be inflationary and would also create certain operational problems. Instead, anesthesia services reimbursement is based on the submission by the anesthesiologist of the surgical procedure code plus time units and, in some cases, modifiers and/or special qualifiers. The American Society of Anesthesiology has requested that HCFA adopt the current CPT-4 codes and guidelines in the anesthesia section. HCFA has requested that Mandex, Inc., as part of a study already underway dealing with HCPCS standardization in six carrier areas, collect information to address this policy issue. This present report describes observations based on site visits and discussions with the six carriers and with practicing anesthesiologists in each of the six carrier areas. A preliminary study design and limitations of the study are also presented.

Findings are:

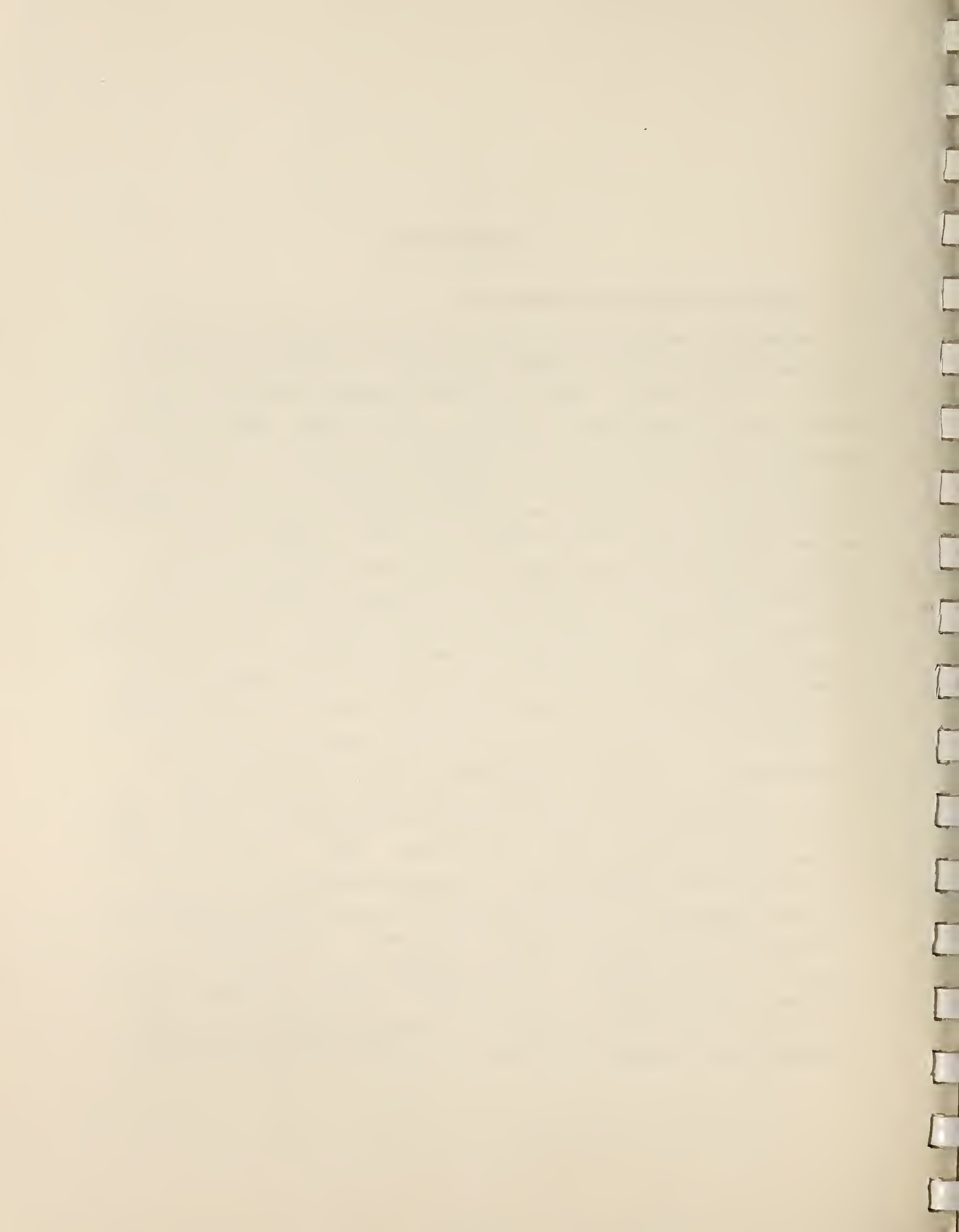
- There is a high degree of variability as to the details of anesthesia reimbursement practices used by the carriers visited. A simple study cannot provide complete information regarding the impact of the change for those carriers unless certain assumptions regarding use of modifiers are accepted
- Because of the large differences in practices among the six carriers visited, it is recommended that certain minimal information on anesthesia reimbursement be obtained from all carriers (a suggested check list has been prepared)
- There would be real operational problems associated with the conversion to the ASA coding system, and more so if the guidelines on modifiers were also adopted
- A study to assess the inflationary impact of conversion to ASA codes for Part B reimbursement is feasible if the effects of use of modifiers is excluded from the study. Such a study can be performed using 100 percent BMAD tapes and certain available tapes from carriers participating in unrelated studies. Inclusion of modifiers as study variables requires a complex and expensive research design.



2. INTRODUCTION

2.1 Background on Anesthesia Reimbursement

Although the methods and specifics of anesthesia reimbursement developed differently among different anesthesiologists and in different parts of the country, it was customary 50 years ago for the surgeon and anesthesiologist to discuss fees and jointly decide how much each would charge. These decisions gradually became formalized into fee schedules which stated how much the surgeon's fee would be and how much the fee for anesthesia services would be for each listed surgical procedure. Generally, the anesthesia service was covered by a global fee, and the anesthesiologist did not charge extras based on length of time to perform the operation, patient status, or special monitoring. In 1960, the California Relative Value Scale (CRVS) was introduced and numbers of relative value units (RVUs) were assigned to each surgical procedure. Since the anesthesiologist could not control the length of time for the surgery, and to avoid a strong disincentive for anesthesiologists to work with slow surgeons, RVUs were also awarded based on actual length of time. The concept of combining base RVUs and time RVUs and reimbursing for the total RVUs instead of global fees was a creative solution to problems of anesthesia services reimbursement and was rapidly adopted by the anesthesiologists and by major third party payers. The early studies that set the number of base RVUs for anesthesia services, however, did not deal with modifiers other than time units. Thus, a surgical procedure that was invariably performed only on a severely acute patient, only under emergency circumstances, or which involved use of special monitoring procedures or equipment was awarded higher numbers of base RVUs. The 1967 guidelines issued by the American Society of Anesthesiologists (ASA) introduced modifiers, which were also incorporated in the 1969 CRVS. By that time, however, the 1964 CRVS were widely used and which did not include modifiers. Also, some of the base units assigned to procedures in the 1969 CRVS were considered to

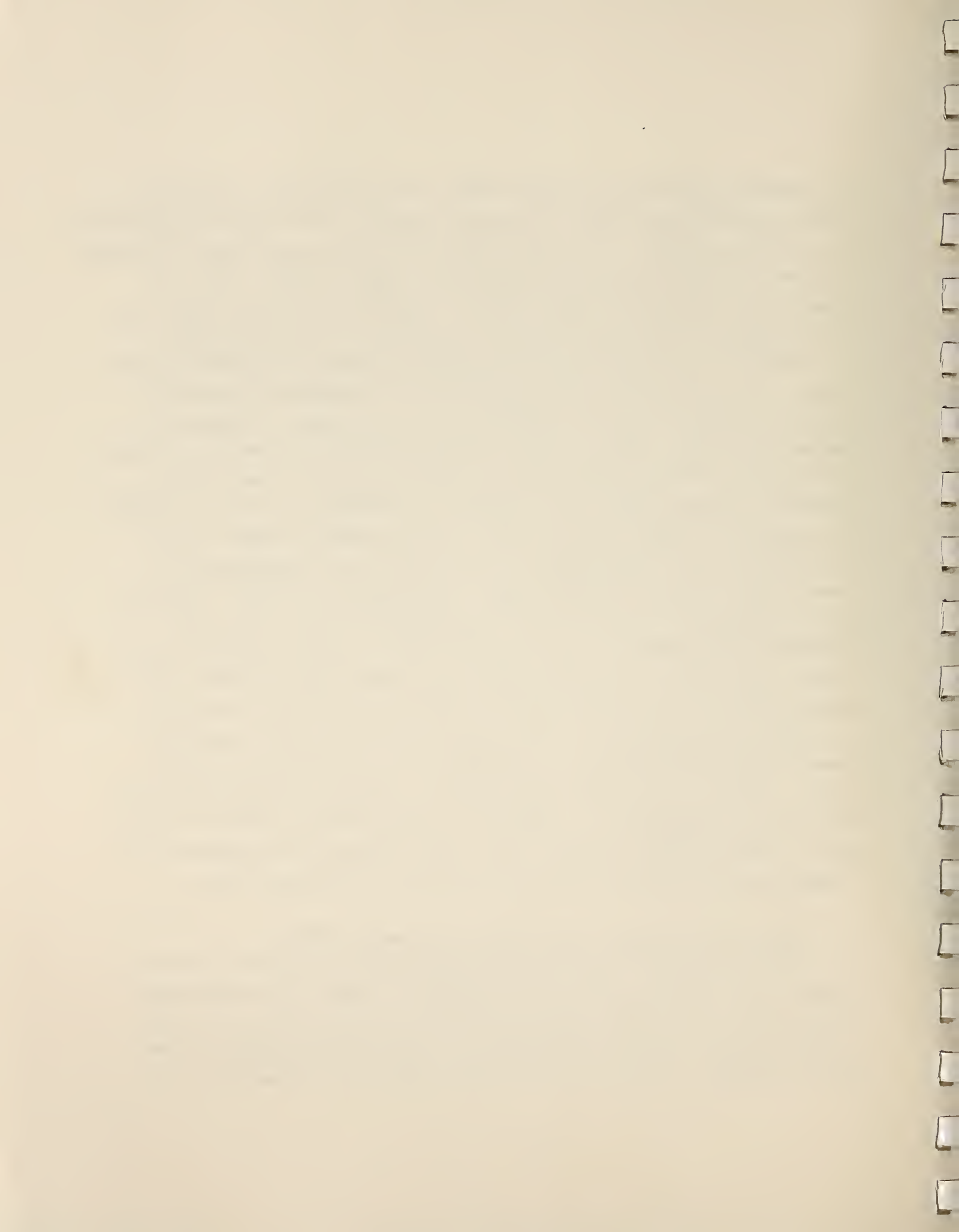


be a "package price" which included certain items which might be separately billed or which might warrant a modifier with award of extra RVUs when considering less complex procedures. Open heart surgery invariably required many monitoring lines and some payers maintained that central venous pressure (CVP), for example, was included in the high number of base RVUs, and did not permit the anesthesiologist to "unbundle" and charge separately for CVP monitoring.

In 1975, the ASA published a very different approach to anesthesia guidelines. For the first time, the guidelines did not reference the specific surgical procedures, but instead adopted unique codes based on anatomical regions and systems. RVUs were then assigned for each such code and represent a single base RVU value for anesthesia services in support of any surgical procedure performed in the region, system, or subcategory of type of procedure. The 1985 CPT-4 includes ASA guidelines, which for example, suggest a basic unit value of 6 plus time units for all intraperitoneal procedures on the lower abdomen (CPT-4 code 00840) except: amniocentesis (4 units), abdominal-perineal resection (7 units), radical hysterectomy (8 units), etc., etc. These guidelines state that the base units cover all usual anesthesia services except time, including "usual pre-operative and post-operative visits, the administration of fluids and/or blood incident to the anesthesia care and usual monitoring procedures." The guidelines do indicate that specialized forms of monitoring and unusual requirements are not included in the base units. The use of a physical status modifier is assumed, but other modifiers are classified as "optional". Qualifying circumstances are reported through use of a separate additional code (e.g., 99140 indicates that anesthesia was "complicated by emergency conditions" and warrants 2 additional RVUs).

2.2 Current Medicare Part B Anesthesia Reimbursement Methods

The basic current Medicare reimbursement system for anesthesia services combines two elements: (1) carrier developed base units for providing anesthesia services during each surgical procedure, usually based on early CRVS or ASA guidelines, and (2) anesthesiologist time units, measured in fifteen-minute increments. There are other elements that may be introduced by the



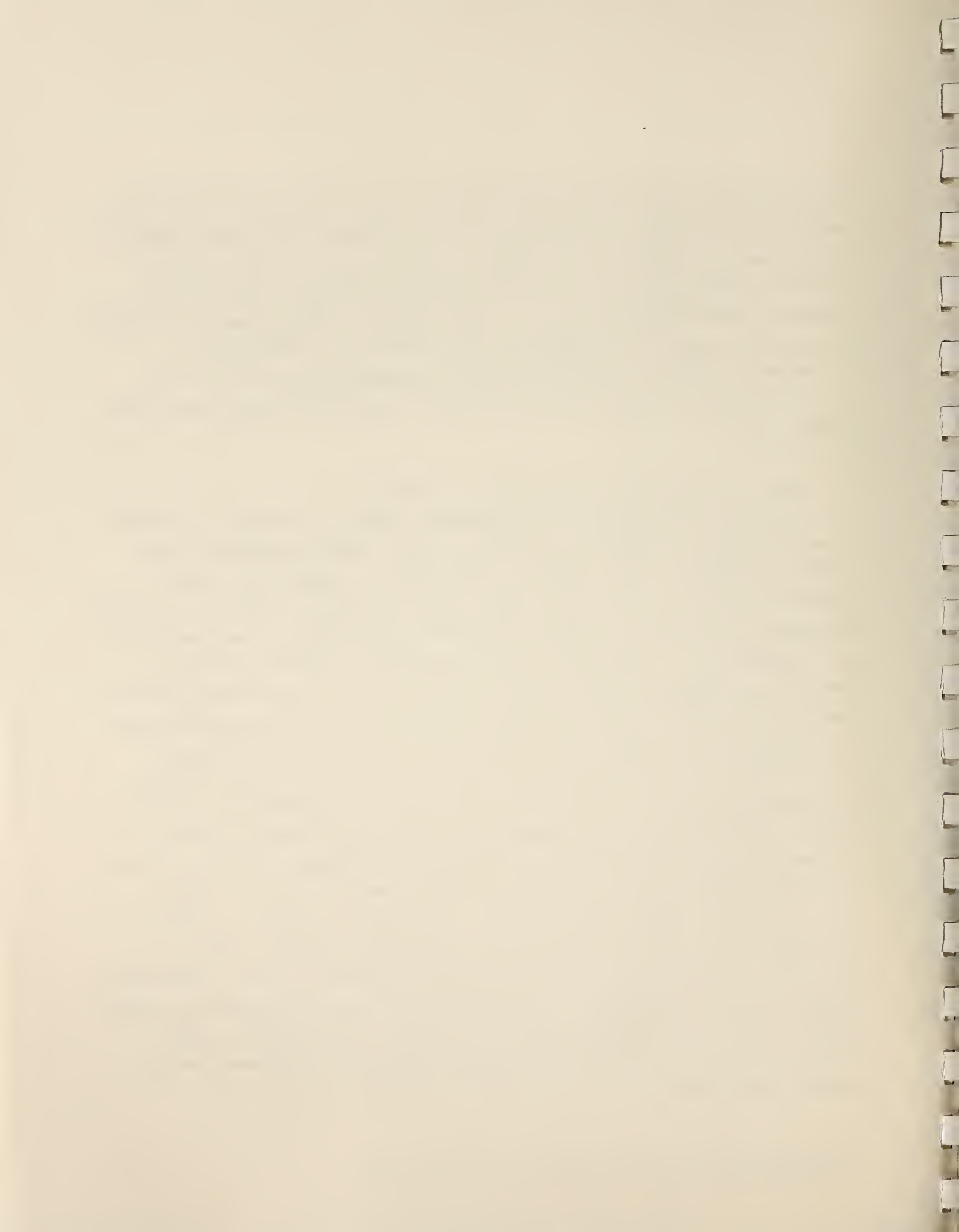
Medicare carriers such as the age and/or condition of the patient and various "modifiers," but these vary by carrier. After October 1, 1983, the Medicare program required carriers to determine a customary charge conversion factor for each anesthesiologist and to derive prevailing charge limits from the customary charge conversion factors. The reasonable charge payment for anesthesia services furnished by physicians must be based on a combination of (1) relative value units (RVUs) and dollar conversion factors and (2) the use of the surgical procedure codes contained in the CPT-4 portion of the HCPCS coding system.

2.3 American Society of Anesthesiologist Proposal

The American Society of Anesthesiologists (ASA) has developed an alternative reimbursement system that converts the CPT-4 surgical procedure codes to CPT-4 anesthesia codes. This is accomplished by grouping the surgical procedure codes into a relatively small number of anesthesia codes. For example, 68 surgical procedure codes were combined into one anesthesia code identified as: "Anesthesia for procedures on facial bones; not otherwise specified." The ASA has assigned a single base unit value to each of the anesthesia codes.* Thus, each of the 68 surgical procedures has been assigned the base unit value for "Anesthesia for procedures on facial bones; not otherwise specified."

The ASA codes and guidelines have been incorporated into AMA's CPT-1985 as 13 pages of codes, relative values, and modifiers. The ASA has criticized current Medicare Part B reimbursement procedures as not being an accurate reflection of the services rendered by the anesthesiologist. ASA has therefore petitioned HCFA to adopt the CPT-1985 Anesthesia Section as part of HCPCS and to use it for reimbursement purposes. ASA points out that the anesthesia section of CPT is the only section which HCFA did not include in HCPCS. In late 1984 the ASA proposed to HCFA that the ASA undertake a study to demonstrate budget neutrality between the presently used coding and the proposed new coding system. The ASA study design called for recoding a representative sample of Part B paid claims submitted by anesthesiologists and then comparing the reimbursement which would have resulted with the actual amount paid.

* See 1982 revision of the ASA Relative Value Guide.



2.4 Purpose and Scope of Present Report

At the time of the ASA proposal to HCFA, a study of HCPCS standardization was already underway which focused on other issues. However, it was determined that only minor modifications to study activities would be needed to use the existing study (being carried out by Mandex, Inc. under Contract No. 500-84-0036) to collect sufficient background information to permit design of a simple and short-time-frame study, or to determine whether a useful study is even feasible.

The present report describes the findings from a survey of anesthesia reimbursement methods and issues from six carriers and from interviews with anesthesiologists in these carrier areas. The report is designed to describe the operational difficulties which a conversion to the ASA codes would create, to describe how a feasible and simple study might be carried out, and to then indicate the difficulties in the interpretation of such a study for national policy decision-making. Recommendations have been included, but it is beyond the scope of the present limited report to design a comprehensive study to address all issues raised by the proposal to change to ASA codes. Also, the present study authorization extended only to practices in six carrier areas, a sample which originally was thought to be sufficient to determine the major patterns of anesthesia reimbursement practices under Part B.



METHODOLOGY

3.1 Carrier Site Visits

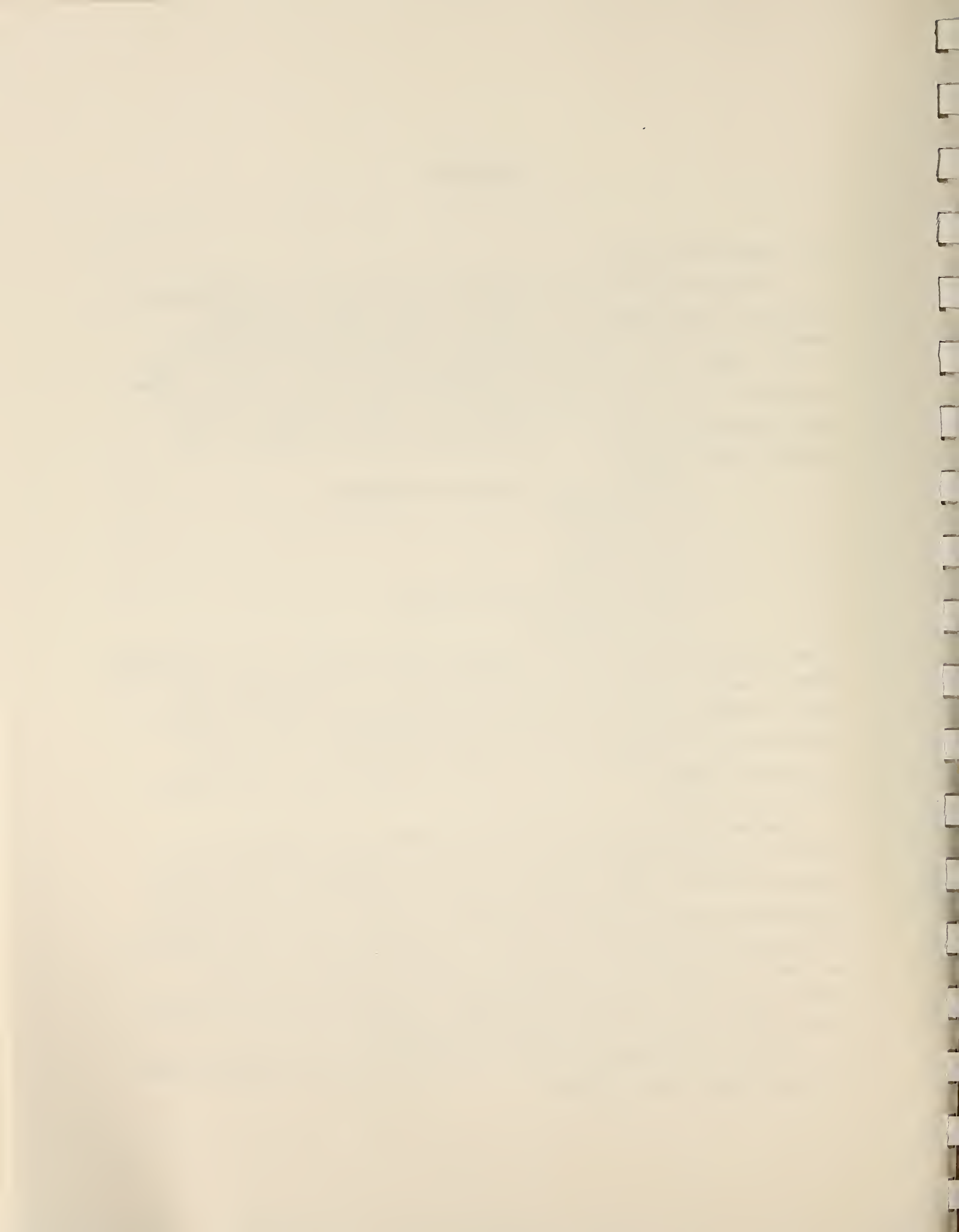
As part of the HCPCS code standardization project, six carriers were selected for participation in a study to assess current coding data quality. For each of these carriers site visits were made during June - July, 1985 to review the HCPCS implementation process, extent of coding by carrier staff, types of edits applied to codes, and whether pre and post intervention measures of coding quality would be feasible. The carriers selected were:

- CIGNA (formerly Connecticut General)
- BS of Maryland
- BS of Florida
- BS of Indiana
- Washington Physician's Service
- BS of California

These carriers were selected to include six HCFA regions, all had implemented HCPCS at least 9 months prior to the site visit, they included a wide range of EMC experience (low for CIGNA and Washington, high for Florida and Maryland, intermediate for California and Indiana), a wide range of carrier standard scores, and a variety of preexisting coding systems used prior to HCPCS.

During each of these site visits the carrier staff was asked to describe the anesthesia services reimbursement methods being used, their origin, and what, if any, problems they were experiencing. The CPT-1985 anesthesia codes were then described and the extent to which each carrier has assessed the implications of such a conversion gauged. This information was used to identify and classify operational problems in using such codes, caveats for the conversion process, if applicable, and to identify any previous studies which may have been carried out.

A site visit report describing observations collected during meetings with each carrier was prepared.



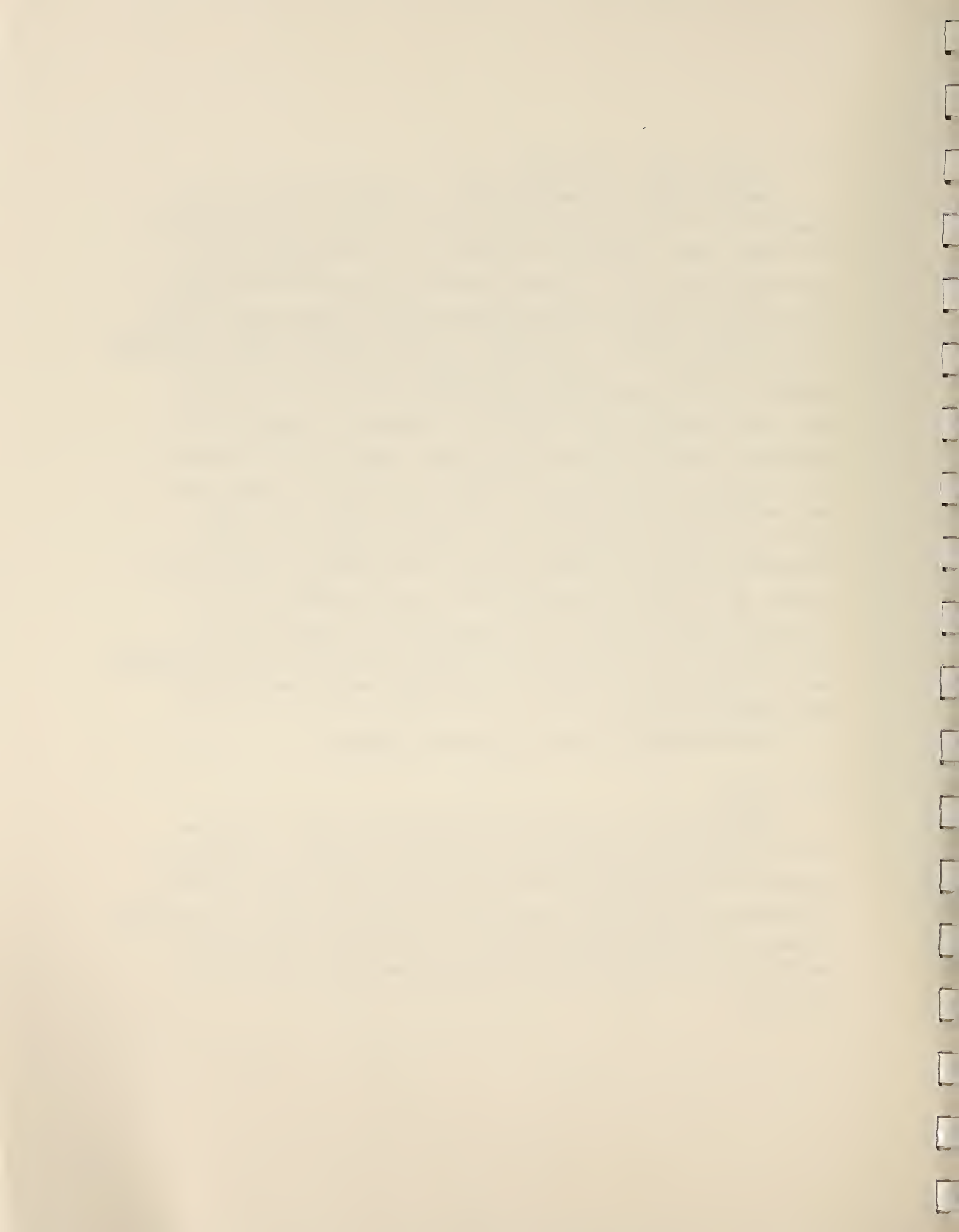
3.2 Anesthesiologist Interviews

Through the ASA an anesthesiologist or anesthesiology group was identified in each carrier area that would be willing to meet with the site visit team. Meetings were scheduled to be accommodated during the carrier site visits, although the actual discussions were held at the hospitals where the anesthesiologists practiced and/or their offices in an adjacent building. In addition to those anesthesiologists identified through the ASA, one interview was arranged to pretest the interview protocol with an anesthesiology group well known to one of the study team. Each interview traced the flow of information, starting with who entered what into the anesthesia record, where did the information come from, was it in narrative, pre-coded, or check-off format, what was transferred to the charge slip, additional coding, who prepared the bill, and any additional coding. Special attention was given to determining whether monitoring procedures were separately itemized and billed, use of patient status modifiers, use of qualifiers, and use of optional other modifiers. The concerns of the anesthesiologists about using the ASA codes versus the surgeon's procedure code were assessed, and their perceptions of Medicare reimbursement versus that of other major payers solicited.

A brief synopsis of each interview was prepared.

3.3 Analysis

Following the site visits and interviews the reports, interview notes, and materials gathered were reviewed and analyzed. In addition, materials obtained from ASA or from other groups within HCFA, and from discussions with ASA or HCFA representatives have been used in our analyses. Because of the very preliminary nature of this report, a quantitative analysis was not warranted and the findings are highly qualitative at this point.



4. FINDINGS

4.1 Summary of Observations Regarding Carrier Operations*

The overwhelming impression based on discussions with representatives of six carriers is that the variation among the carriers with respect to reimbursement for anesthesia services is very large. For example, the origin of the presently used base RVUs included:

- 1973 Blue Shield Guide
- 1967 ASA Guide
- 1969 CRVS
- 1980 ASA
- 1982 FMARVS

The practices of the carriers were particularly divergent with respect to recognition of modifiers as represented by the following examples:

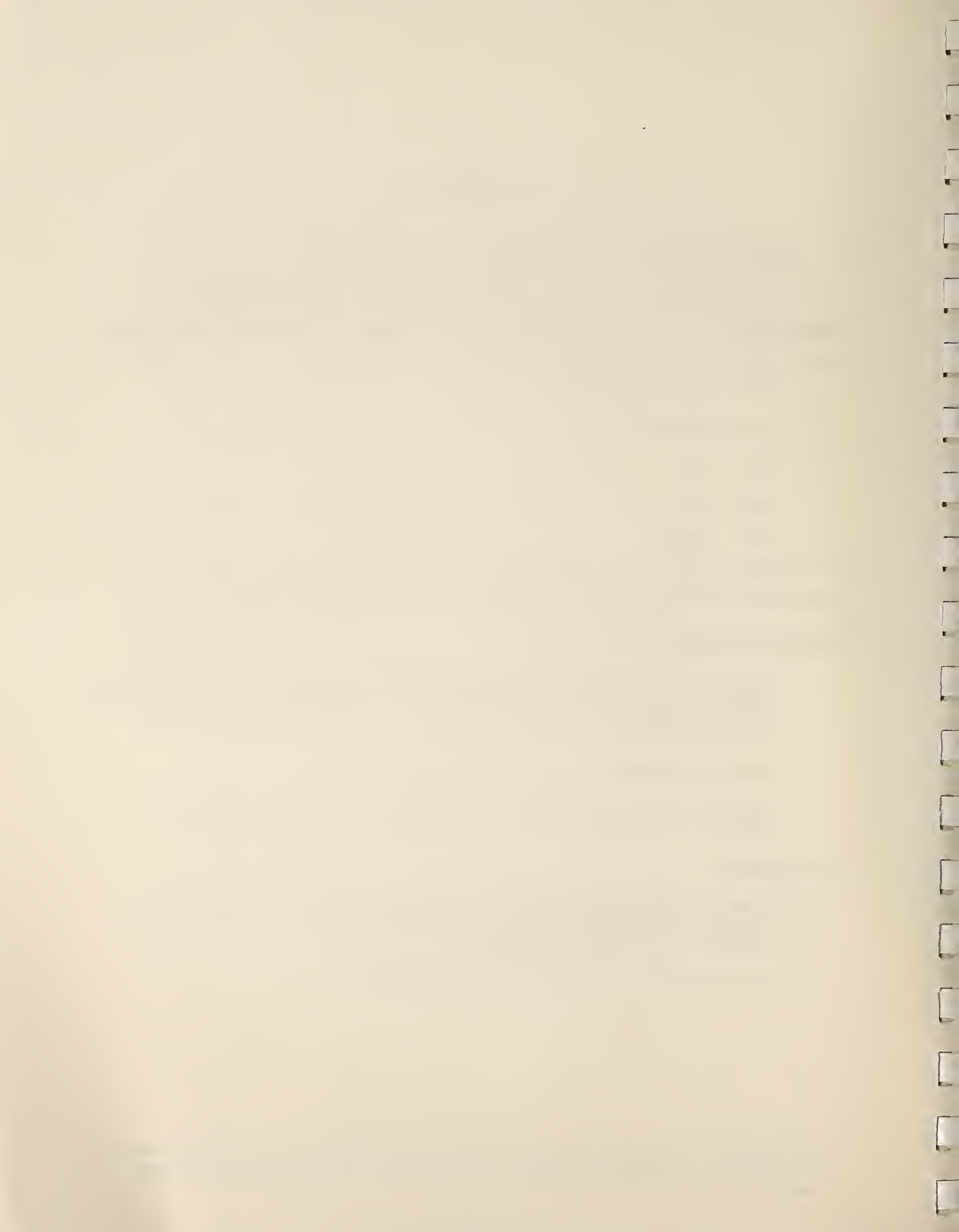
Washington Physician Service (WPS)

- For some surgical procedures, but not others, allow a separate reimbursement for central venous pressure (CVP) monitoring (the professional affairs committee sets the guidelines as to whether it is included in the base units)
- Recognize patient status of P3 and above
- Recognize special qualifiers (use separate code on second line of bill).

BS of Maryland

- Do not give additional reimbursement for arterial lines, CVP, etc. However, insertion of a Swan-Ganz catheter may result in extra reimbursement for certain procedures
- No recognition of patient status modifiers.

* A collection of the carrier site visit reports appears in a separate report. The reports on the anesthesiologist meetings are appended to the present report.



BS of Indiana

- Recognize physical status modifiers
- Reimburse extra for arterial lines, CVP, and Swan-Ganz catheter, but not for all procedures
- Recognize special qualifiers
- After 2 hours the time unit basis for additional time drops from 15 minutes to 12 minutes per RVU (applies only to anesthesiologists in the Indianapolis area).

BS of Florida

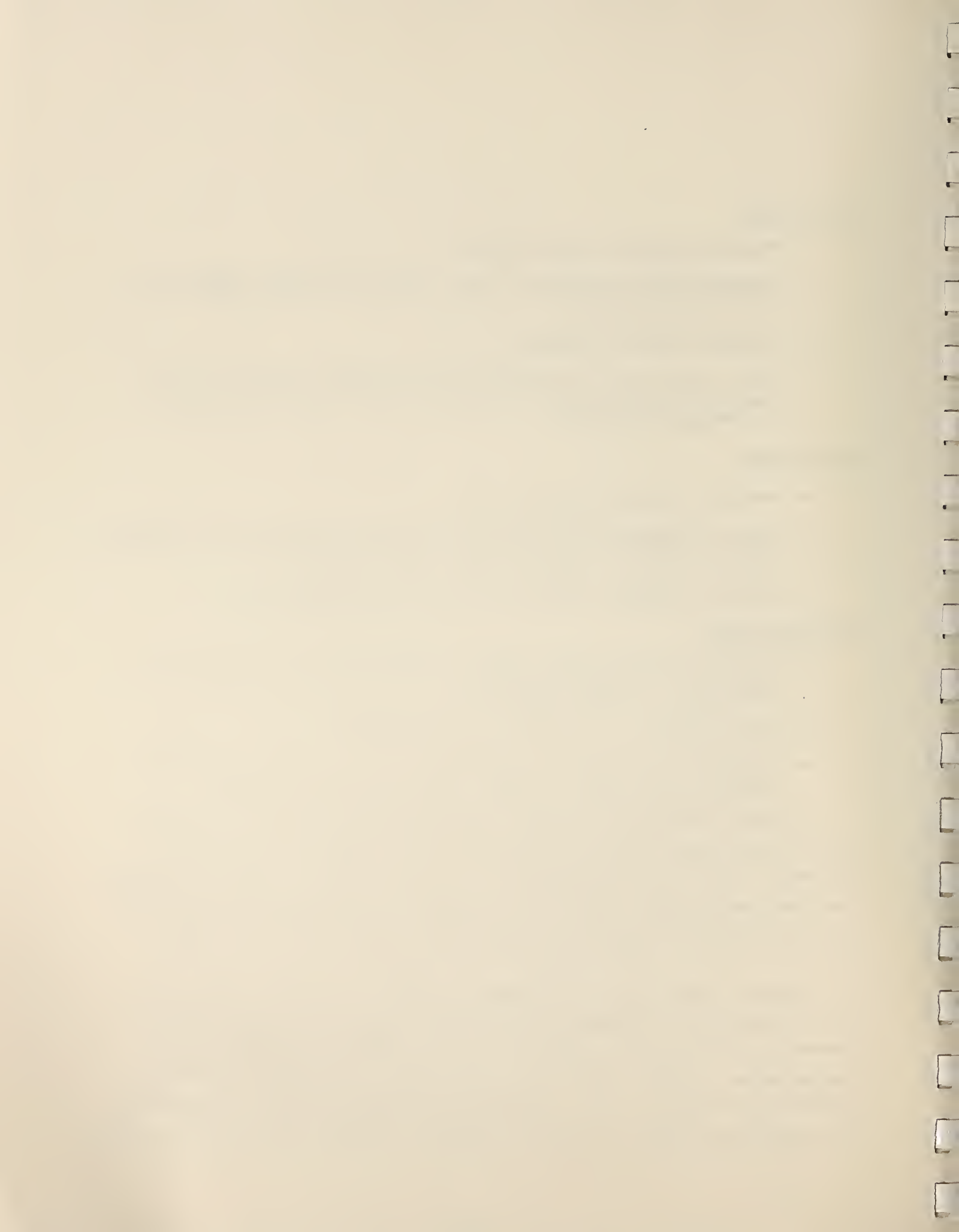
- Does not recognize physical status
- Does not reimburse extra for arterial lines or CVP, and only reimburse extra for Swan-Ganz catheter with certain procedures
- Does not recognize other modifiers or special qualifiers

BS of California

- Recognize P3 and above for physical status unless the surgical code duplicates the status information
- Most monitoring is considered to be "included"
- Special qualifiers may be recognized, but as for the physical status modifiers, they require a special report with justification.

Of special importance for study design was the finding that the history file for each carrier contains only the surgical procedure and the sum of the RVUs. Thus, extra reimbursement due to physical status cannot be separated from that due to time. Therefore, a recoding using ASA 1982 codes would have to be done without recognizing modifiers unless we go back to the original bill.

Carriers raised a number of important operational issues concerning the CPT-1985 anesthesia codes and guidelines. First, many of the existing data processing systems cannot handle the additional modifiers without extensive reprogramming. Second, about half of the carriers are believed to presently differentiate whether or not to reimburse for an unusual monitoring procedure or a Swan-Ganz catheter, based on the surgical procedure code--an ability which



could be lost in the conversion and lead to inflationary "unbundling" of previously "included" procedures. Other concerns expressed were:

- Multiple trips to operating room on the same day, as often happens with a kidney transplant patient, would appear to be duplicate billing.
- It would be impossible to differentiate cosmetic from medically necessary procedures unless the carrier waited for the surgeon's bill or retroactively recovered inappropriate payments.
- Screening criteria for time units as a function of procedure performed would be less valuable.
- Many problems would be encountered in the conversion from Level 3 to ASA/CPT-1985 codes. HCFA should distribute the Level 1 and Level 2 conversions if there is a changeover, since there is too much flexibility and very specific guidelines will be needed.
- What would be done with anesthesia for surgical procedure codes that don't fall into any of the ASA categories?
- What would be done with those CPT surgical codes when can go into more than one ASA category?
- How would newly developed and more complex procedures be handled-- they might warrant more than the base RVUs for the body region?

All carriers can provide a tape with the number of base RVUs for each surgical procedure code.

Because of the large differences in anesthesia services reimbursement methodology, it is recommended that HCFA collect and compile certain minimal information from all carriers. This information would be useful for interpreting the current findings and for further consideration of the design of a study to provide quantitative data regarding the inflationary impact of use of ASA codes. A draft checklist which could be used by HCFA Regional Offices to collect carrier methodologies for anesthesia services reimbursement appears in Exhibit 1.

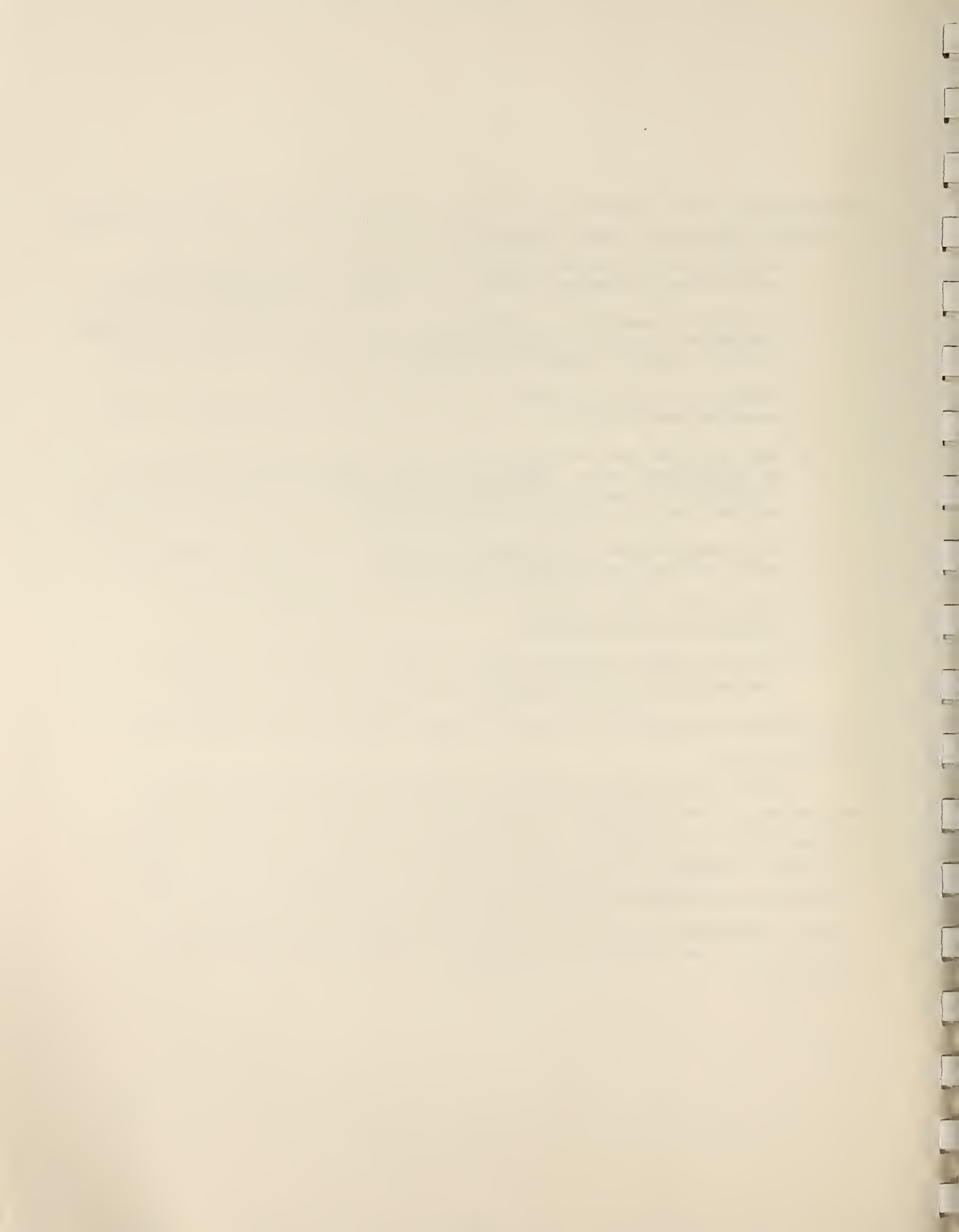


EXHIBIT 1

Checklist of Carrier Methodologies
For Anesthesia Services Reimbursement

1. Carrier Name and Address _____

2. Name and phone number of contact for further information regarding anesthesia services reimbursement

Name _____

Title _____

Phone _____

3. Source of RVU's presently being used (e.g., 1980 ASA Guide, 1969 CVRS, etc.):

4. Does carrier reimburse extra for the following anesthesia circumstances/ services? If so, briefly explain what modifiers are used, how/where indicated on bill, and how reflected in the history file and on the BMAD tape:

4.1 Anesthesia under qualifying circumstances such as emergency circumstances Yes No

If yes, how: _____

4.2 Patient status Yes No

If yes, how: _____

4.3 Special monitoring Yes No

• CVP

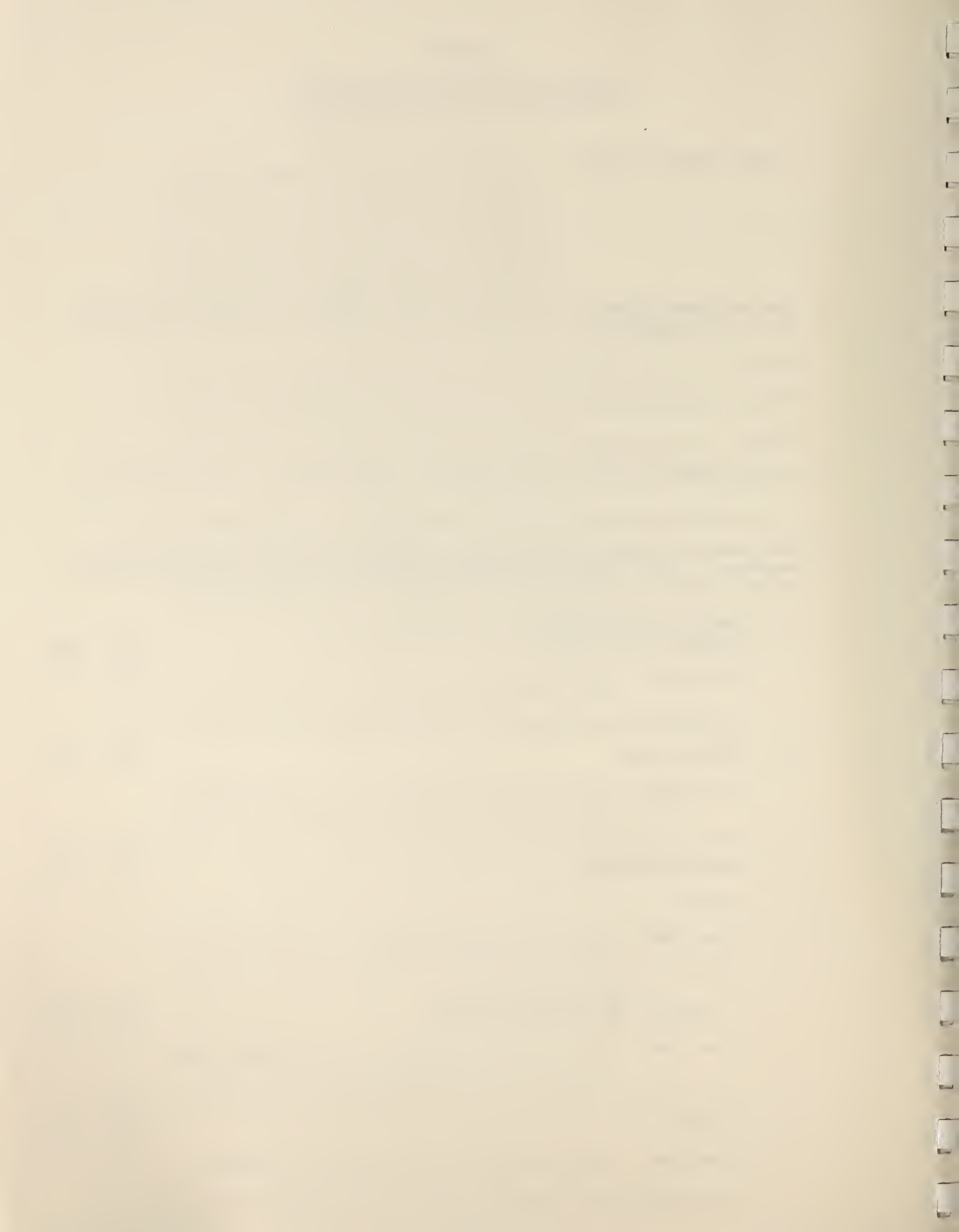
If yes, how: _____

• Insertion of Swan-Ganz catheter Yes No

If yes, how: _____

• Other Yes No

If yes, how: _____



4.4 Extra time units for prolonged surgery

Yes

No

If yes, how: _____

4.5 Field avoidance

If yes, how: _____

4.6 Other

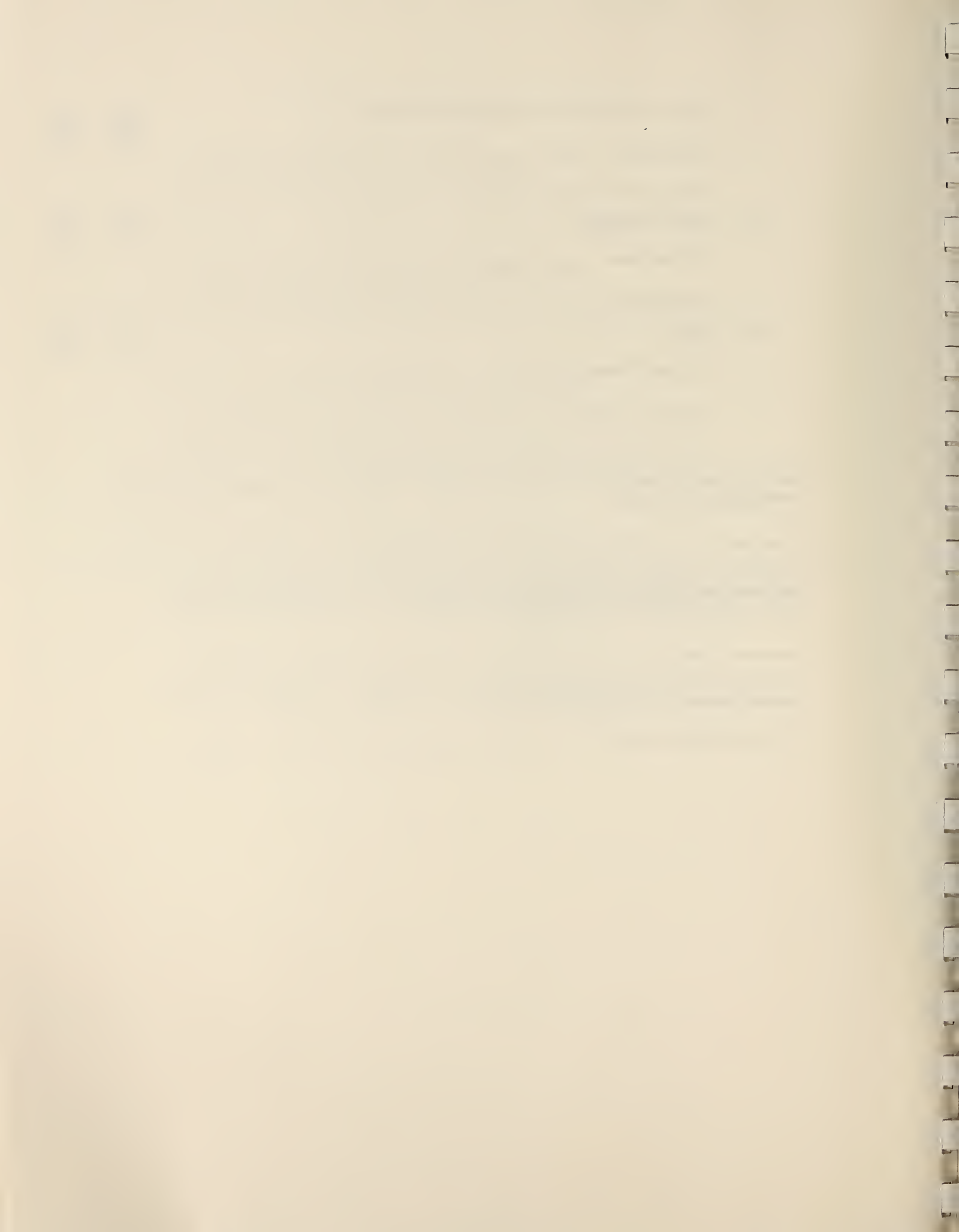
If yes, please describe: _____

5. For how many geographic areas do you have separate "prevailing" limits on anesthesia services?

6. For what estimated proportion of current anesthesia services bills is the anesthesiologist reimbursement limited by the prevailing screen rather than UCR for each anesthesiologist?

7. Are there non-anesthesiologists in your area who are receiving Part B reimbursement for anesthesia services? Yes No

If yes, about how many? _____

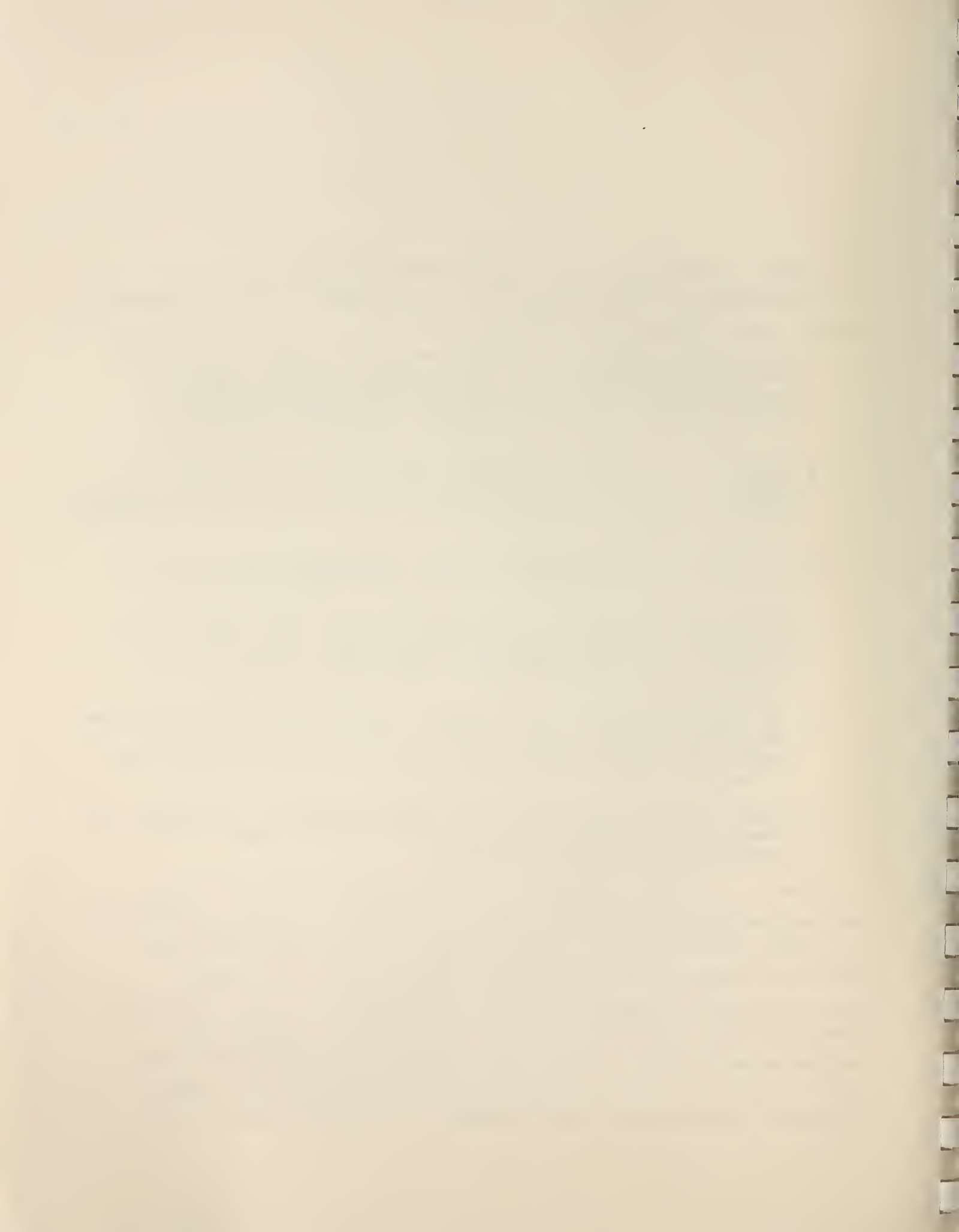


4.2 Summary of Observations From Anesthesiologists Meetings

Brief synopses of each meeting with anesthesiologists appear in the Appendix to this report. Summary observations are:

- Among the anesthesiologists interviewed, there is mixed feeling about the use of the surgeon's code for billing for anesthesia services. Few believed that the present system is burdensome, although some were clearly casual about the precision with which they described the surgical procedure when it makes no difference in reimbursement.
- About half the groups were concerned about carrier recognition of modifiers and/or reimbursement for special monitoring (arterial needles, CVP, etc.) and qualifying circumstances. There also were large differences in carrier practices in this area.
- About half the groups expressed concern that Medicare was not keeping up with reimbursement practices of other major payers in the area.
- About half the groups seemed relatively unconcerned about the details of the Medicare Carrier reimbursement practices (in two out of three of these states, the Blue Shield private business reimbursement of anesthesia services closely resembled that for Medicare).
- All anesthesiologists interviewed used a single system of data collection, regardless of payment source. The actual bill did differ, based on payer in most cases, but information was available on the charge ticket to support rebilling to any other payer.
- There is a general perception among anesthesiologists that the prevailing charge screen is working much more to their detriment than are the prevailing limits applied to surgeons.

Several of the anesthesiologists strongly supported the position that Medicare should use the ASA codes, modifiers, qualifiers, and extra reimbursement for unusual monitoring, but only one suggested that the dollar reimbursement per RVU be reduced in proportion to the increased number of RVUs awarded. There was general recognition that such a conversion would produce operational problems to permit identification of covered/non-covered procedures and to address potential double billing issues. Suggestions were made that it might be necessary to wait for the surgeon's bill or the hospital bill to address these, but that they would be minor problems in comparison to the benefits.



4.3 Preliminary Study Plan

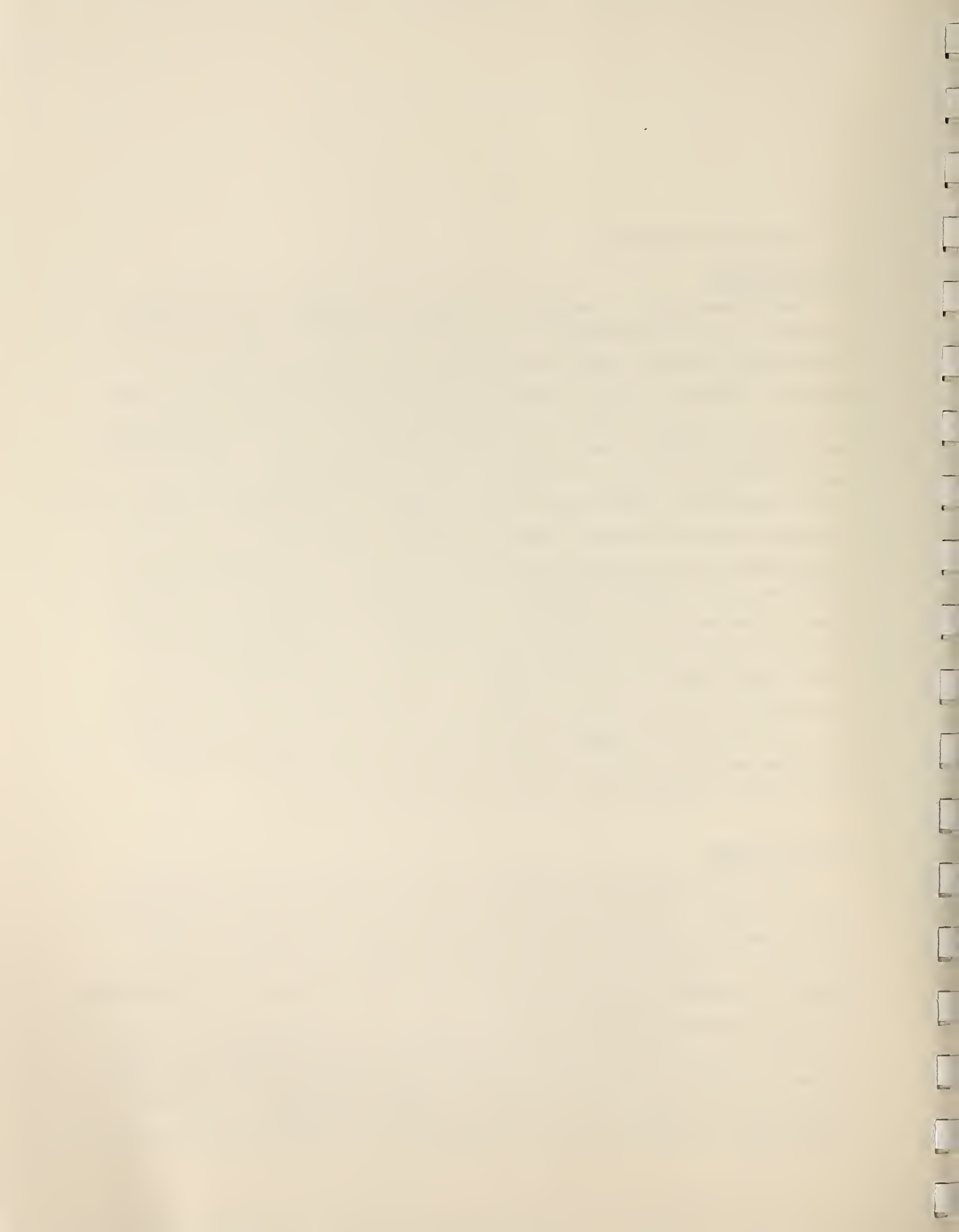
Data to be Used

The proposed study is designed to compare the payments that would have been made using the basic Medicare reimbursement system and those that would be made using the ASA proposed coding system, excluding the effects of modifiers. Medicare carriers data for services provided during 1984 for three of the six carriers to which site visits were made will be used. These data are available to HCFA as part of the set of 100% history tapes being furnished under the BMAD umbrella by 14 carriers. Data are also available for four carriers (Minnesota, North Dakota, South Carolina, and Washington) who are providing 100% claims history records to Mandex. Because each carrier's reimbursement procedures differ in detail, but are alike with regard to the use of the CPT-4 surgical procedure codes and time units (actually the total RVUs for time and all other modifiers recognized by the carrier), only these two data elements will be common for all carriers. To enable application of the proper base units and conversion factors to each carrier's data, a tape record of these two key data elements will be obtained from each carrier. The tape record of the grouping of each CPT-4 surgical procedure code into the CPT-4 anesthesia codes with the RVG base units that have been assigned to each CPT-4 anesthesia code will be obtained from the ASA.

Tabulation Plan

Data will be selected to include all records within the type of service code, anesthesia. These records will be categorized on the basis of specialty code to separate anesthesiologists from surgeons and other physicians who may have been billing for anesthesia services. An attempt will also be made using the frequency distribution of the time units to separate direct anesthesia services from supervisory services.

The surgical procedure codes as defined by the anesthesiologist and contained on the bill records will be matched to the carrier's tape of base units and a total of the base units for each procedure code obtained. Similarly, these surgical procedure codes will be matched to the ASA tape and the total



base units obtained. Comparison of these two totals will be made and differences will be evaluated. The net difference across the entire set of a carrier's data will provide the basis for estimating the dollar impact of a change from the current system to the new CPT-4 (ASA) system.

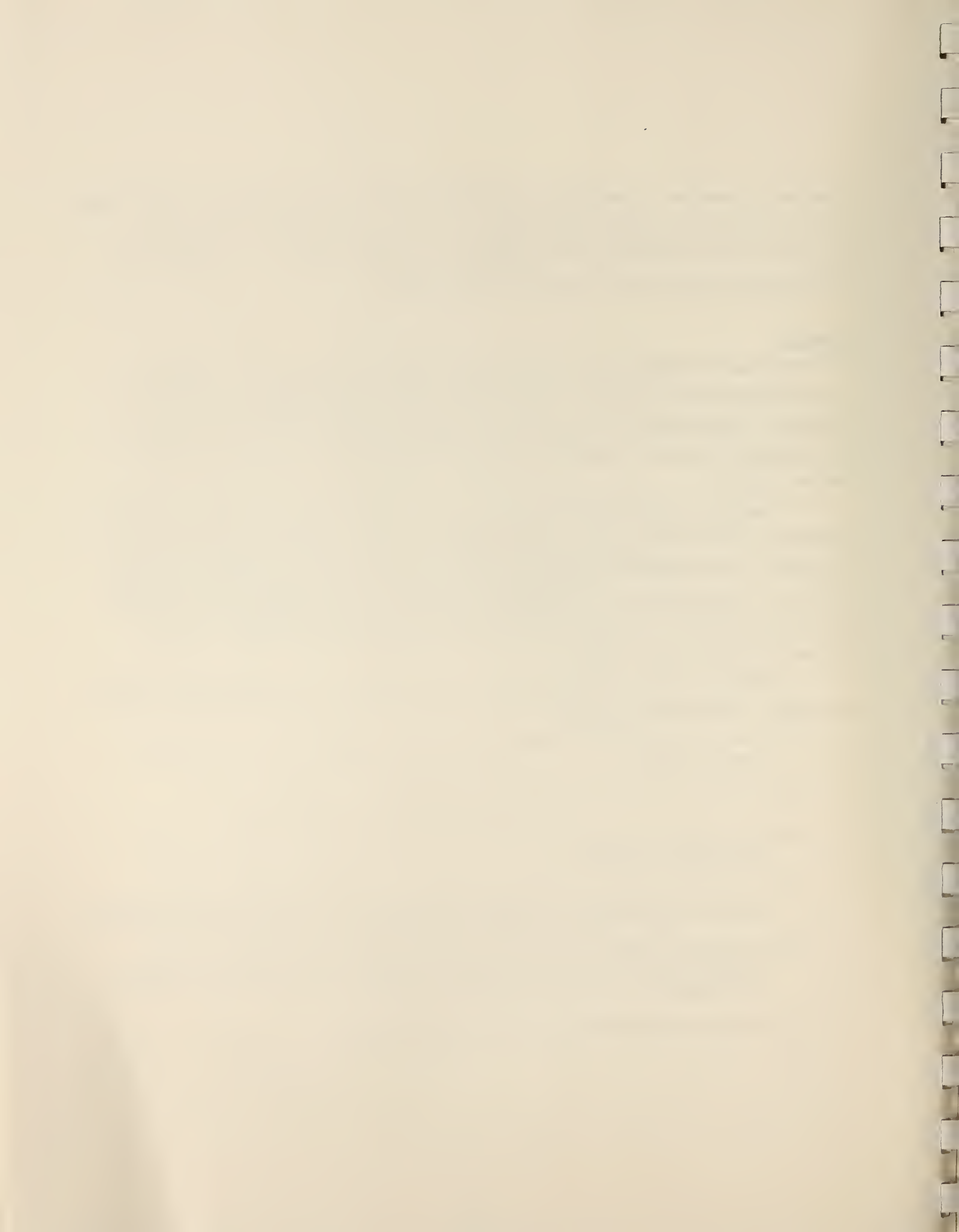
Comment

The plan for the study is relatively simple and is designed to conform to the fundamental issue, i.e., what is the affect of changing the base for anesthesia reimbursement from detailed surgical procedure codes as reported by anesthesiologists to grouped surgical procedure codes as proposed by the Society (ASA).

It should be recalled that there is often a disparity between the surgical procedure code billed by the surgeon and that billed by the anesthesiologist. In effect, some anesthesiologists are currently reporting a surgical procedure code that is appropriate to the general body region (the proposed ASA system), but make no effort to report the code that describes the procedure carried out and billed by the surgeon.

To evaluate whether such practices already impact the reimbursement system, we propose the following steps:

- (1) Select all bills for surgical services using the type of service code, surgery.
- (2) Select all bills for services provided by anesthesiologists.
- (3) Match these two sets of bills on the basis of HIC numbers, place, and date of service.
- (4) Using the carrier's base unit tape, apply these anesthesia base units to the surgical procedure codes billed by the "matched" surgeons.
- (5) Using the carrier's base unit tape, apply these anesthesia base units to the surgical procedures reported by the "matched" anesthesiologists.
- (6) Compare total base units for each specialty.



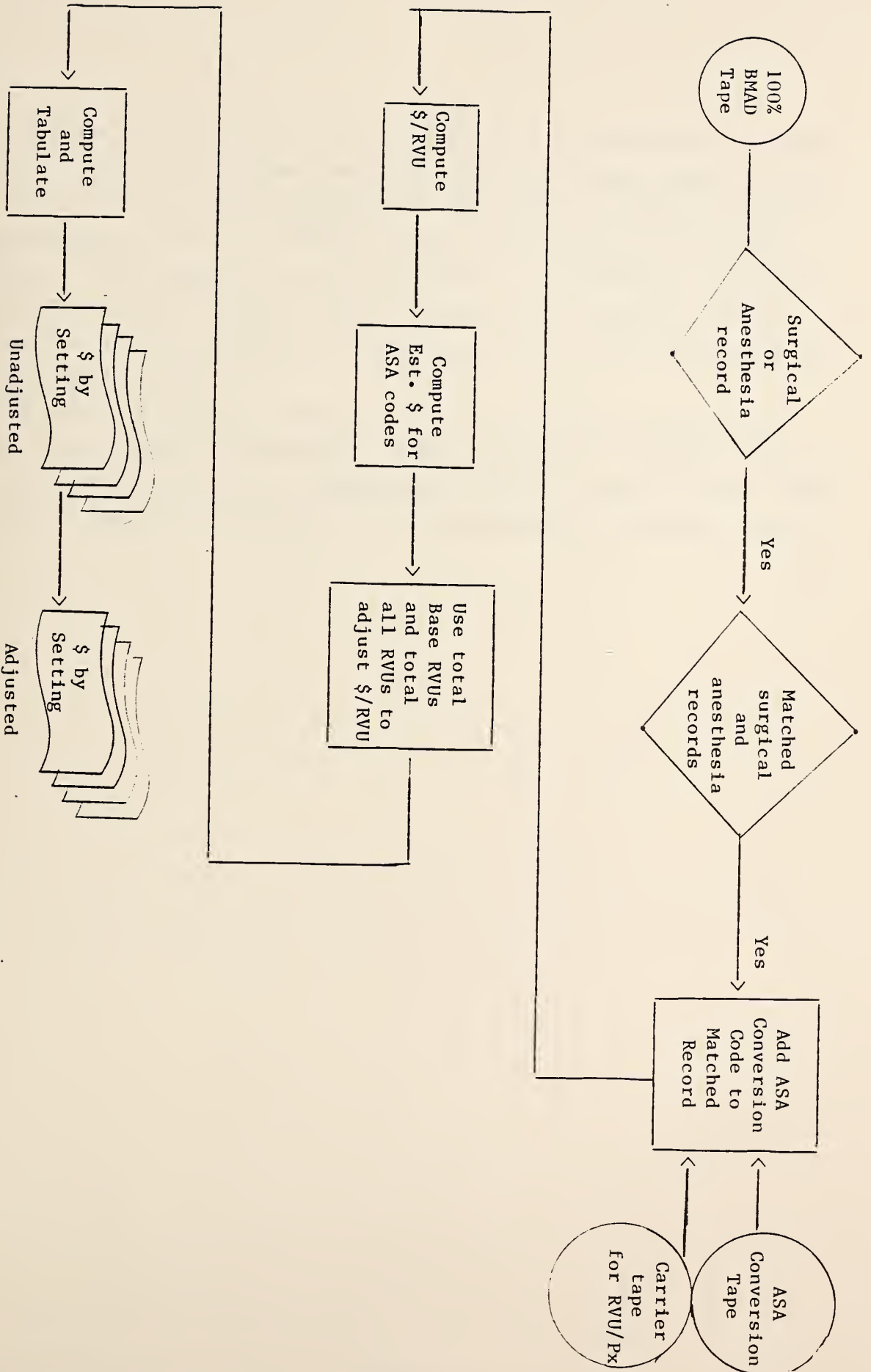


CHART NO. I

The steps described do not include examination of the effects of anesthesia time units or the various modifiers for the following reasons. The time units billed by anesthesiologists for each surgical-anesthesia service are unchanged by the use of different RVUs or descriptors of the surgical procedure. The acceptance and use of modifiers by the Medicare carriers is highly variable and in addition, some carriers do not separately identify each modifier (and its weight) that is included in the final combination of units applied to the RVU.

The data will provide estimates of the cost differences between the present basic system both as currently (1984) reported by anesthesiologists and as it currently would be if true surgical procedure codes and their RVUs were used to compute the base units for reimbursement of anesthesiologists.



4.4 Other Issues and Caveats

The preceding described study design will provide empirical data concerning the differences in numbers of base RVUs between existing and ASA proposed systems in the carrier areas studied. These can be analyzed in aggregate, by setting (e.g., hospital inpatient, hospital outpatient, or ASC), for relatively new procedures with high growth in volume versus well established or declining volume procedures, or for surgical procedures selected for other reasons (most frequent 100 procedures, for example). However, the study findings will have to be conservatively interpreted because of the following limitations:

- For carriers not now recognizing physical status modifiers, the impact of the change to use of ASA codes and modifiers cannot be determined without a much more detailed study, involving going back to the anesthesiologist's records (charge slips or anesthesia record) in some cases, and to the original bill in others. If we assume that carriers not now recognizing modifiers would continue to do so, the ASA codes and RVUs would result in an average decreased reimbursement if the system with modifiers is actually budget neutral
- Determining which monitoring procedures are "unusual" and warrant separate reimbursement will be difficult using the ASA codes. The ASA statement that the base values include usual monitoring will have to be redefined in operationally useful terms, a major undertaking unless other payers or ASA already has such a scheme. Without such a scheme the potential for "unbundling" and inflationary impact cannot be measured.
- The study to date has dealt with only six carriers, each of which was found to have unique features in its anesthesia reimbursement. Generalization to other carriers is, therefore, unwarranted at this time, and there is an urgent need for some minimal information regarding anesthesia reimbursement practices for each.



APPENDICES

ANESTHESIOLOGISTS MEETING NOTES



SITE VISIT REPORT

Howard County General Hospital and John Payne, PA

March 29, 1985

The visit began in Dr. Payne's business office in the building next to the hospital. After reviewing billing procedures there with Dr. Payne's office staff the site visit team (Harry Savitt, Alan Bradt, and Ben Duggar) went over to the OR Dept. at the hospital and interviewed Dr. Payne between procedures. Key observations were:

- The hospital admitting office provides a copy of the admitting form to anesthesia for every surgical patient. Key information is:
 - insurance information
 - admitting diagnosis and expected surgical Px
 - admitting physician and surgeon, if applicable
- After the anesthesia is administered the anesthesiologist prepares the anesthesia record for the patient. A "tear off" portion is the "procedure ticket" which is used for billing (when matched to the admission form). The procedure ticket contains:
 - Who administered the anesthesia
 - Type anesthesia and units
 - Time
 - What surgical procedure(s) performed
 - Notes (this is where high risk, etc. is entered).

Copies of the completed anesthesia record, including the procedure ticket go to: 1) the medical record, 2) anesthesia record. The tear off charge ticket goes to: 1) hospital, and 2) anesthesiologist.

There is a line on the anesthesia record for circling the physical status modifier (e.g., P1, 1, 3 ---).

- Anesthesiologist determines the "units" on each procedure ticket, business office worker codes the narrative operation description in CPT (admitting Dx already coded on admitting slip from hospital).

- Different payers want different info on bill (private insurance wants start/complete times recorded, for example).
- Dr. Payne uses a billing service in Baltimore -- has an on-line terminal for entering the billing data. When the billing clerk enters the Px code in CPT the screen displays the narrative to go with it.
- Billing service does tape billing to MD Blue Shield -- hard copy to GHI. The forms or listings are sent back to the anesthesiologist for review before being sent to the carrier.
- Key in bill about 2-3 days after surgery --- review bill 1-2 days later --- mail off 1 week after surgery.
- Dr. Payne's office generates about 150 bills/wk. If have 2 trips to OR for same pt., can combine billing.
- Computer screen format is same for all insurance --- staff puts in what they know is needed based for the specific pts. insurance co.
 - File bill in office alphabetically.
- Hospital Anesthesia Department:
 - Anesthesia record filed by date of Px and name of pt.
 - Anesthesiologist codes ASA RVUs --- office codes surgical Px, depending on insurance.
 - John P says they seldome use the "severity" (physical status), qualifying circumstances, or other modifiers. This may be reducing their reimbursement, but that's OK.

The general flow of information is depicted in Exhibit 1.

DECISION TO PERFORM SURGERY

- Insurance
- Admitting Dx
- Planned Px
- Physicians

Patient Processed in Admitting Office

Admitting Forms

Various Hospital Departments

Medical Records

Surgery Dept. & OR Desk

Pre-Op Reports
• History & Phys.
• Preanesth. Eval.
• Diag. Tests

Prepare OR Schedule for Next Day

Charge Ticket
• Who did Anesth.
• Type Anesthes.
• RVUs and Time
• Surgical Px
• Notes (modifiers)

Consultations, Nurse's & Progress Notes, Laboratory & Ancillary Rpts

Surgery Performed & Anesth. Admin.

Anesthesiologist Completes Anesth. Record, Determines RVUs, Time, Modifiers

Anesth. Record
• Anesth. Dept.
• Medical Record

Discharge Summary Prepared by Attending Phys.

Surgeon Dictates Operations Notes

Completed Medical Record

Billing Service Prepares Tape and/or Hard Copy

Send Hard Copy to GHI and other than BS of MD

Send To Blue Shield of MD

Transmit on-line Billing Information

Anesthesiologist Business Office
• Prepare Billing Info

Anesthesiologist Business Office
• Review Bills
• Send / Revise

EXHIBIT 1

SITE VISIT REPORT

HARTFORD ANESTHESIA ASSOCIATES
June 19, 1985

The meeting was attended by:

Dr. Meredy - Hartford Anesthesia Assoc.
Mr. Pfizenmayer - Attorney for ASA
Richard Kahan - Statistical Consultant to ASA
Dr. Weiss - ASA Representative

Harry Savitt - HCFA
Howard West - Mandex
Ben Duggar - SAIC

It was explained that Hartford Anesthesia Associates (HAA) submits claims to Medicare in electronic form, using a billing service and on-line terminal. Dr. Meredy is familiar with other groups in the State and indicated that the five largest groups use the same billing service. HAA receives the operating room schedule the day before which lists the patient and type procedure. After surgery the anesthesiologist completes the anesthesia record, one copy goes to the patients medical record, one to the anesthesia department and one to the anesthesiologist. The anesthesia record has check-off items or entries specifically for each of the ASA modifiers as well as places to enter the surgeon's procedure as well as the ASA CPT code. Dr. Meredy takes his copy of the anesthesia record back to his office where it is merged with a copy of the face sheet/admission slip which the hospital sends. Dr. Meredy's secretary codes the procedures using CPT.

A group in Norwalk that Dr. Meredy knows submits hard copy bills to Medicare. These have the ASA codes on them, but the surgical procedure is in narrative form rather than CPT code.

Payment is based on the procedure and time for Medicare, but all of the modifiers for other payers. For example, if an emergency appendectomy were performed for an 80 year old, the ASA guidelines call for:

5 units for base procedure
1 unit for emergency
1 unit for old age
4 units for one hour of surgery
11 units total

Medicare pays:

5 units for CPT appendectomy code
4 units for one hour of surgery
9 units total

It was reported that CIGNA does an annual audit of a sample of EMC submissions to insure they are consistent with the records. For Dr. Meredy the sample is about 12 claims each year.

Dr. Weiss reported that in Massachusetts the anesthesiologist cannot use EMC unless he or she accepts assignment.

It was learned that the 1985 ASA Guide is out now and contains several minor changes (modifiers for transplants and physical status of the patient). Copies will be sent to Dr. Savitt by ASA.

Dr. Meredy raised the question of why the amounts paid to anesthesiologists for similar procedures are very close, but not identical. He cited examples where the amount might be \$ 156.00 for one anesthesiologist and \$ 155.63 for another (possible explanations are: 1) they practice in different localities with differing "prevailing" ceilings, 2) they used different CPT codes for describing the same surgical procedure, 3) their "customary" history differs).

SITE VISIT REPORT

Indiana Anesthesiologists

July 16, 1985

A meeting was held at St. Vincents Hospital with Drs. Steve Young and Wendell Edwards. Dr. Young is chief on anesthesiology at St. Vincents and Dr. Edwards is Director of Anesthesiology at Methodist Hospital, both in Indianapolis. Because Part B anesthesia reimbursement differs outside of Indianapolis, a telephone interview was conducted with Dr. Richard Stein who practices in Vincennes, Indiana located on the border with Illinois about 105 miles to the southwest of Indianapolis.

All three of the anesthesiologists submit paper bills and indicated that there was little EMC by anesthesiologists in Indiana (a bad experience with EMC by an anesthesiologist has made most of them very cautious). It was reported that Medicare Part B in Indiana uses the 1971 ASA guide for determining RVUs. About 20 years ago Blue Shield went to the Relative Value Guide as did some other payers. This was updated from time to time, but Blue Shield refused to update to the 1975 guide. In 1981 Blue Shield initiated the request to go with the 1981 ASA guide and the anesthesiologists agreed. As a result, all charge slips used by anesthesiologists have places for entering all modifiers, even is some of the other payers don't recognize them. However, even if the payer wants the ASA code, they also want a narrative of the surgical procedure. Drs. Young, Edwards, and Stein seemed to prefer the 1981 ASA to the current HCPCS approach. The 1981 adjustments did eliminate field avoidance (SFA) and "position" for procedures with more than five base units. However, Medicare Part B does currently pay for most modifiers, so that is not a problem (the value per unit is a problem for the anesthesiologists who report they typically get 55 percent of Their UCR while surgeons are getting 80 percent of their UCR.

When preparing the charge ticket the anesthesiologist has a sheet from the hospital giving insurance information, attending physician, and surgeon, but the anesthesiologist does not get the operations notes. Thus, he or she

must try to come up with the name of the most complex procedure performed (if more than one) and list it on the slip. Drs. Young and Edwards don't code the procedure, just give a narrative description. Dr. Stein's business office does code the surgical procedure in CPT-4. All of the anesthesiologists expressed ambiguity as to the importance of getting the detail correct on the surgical procedure, since it makes very little or no difference to the reimbursement (e.g., any procedure in the abdomen is 6 units unless there is vascular reconstruction). The charge slip has a place for entering all the modifier information from the ASA guidelines, all extra procedures (arterial lines, catheters, etc.) and the RVUs for each, plus the time units.

Drs. Edwards and Young report that they currently are reimbursed for arterial lines, but sometimes not for a Swans-Ganz catheter, they get a time unit bonus after 2 hours (e.g., the time units shift from every 15 minutes to 12 minutes per unit), they are paid extra for patient physical status, and for unusual circumstances. We were showed an example in which Medicare paid only 59 of the 64 units charged as follows:

	<u>RVUs</u>
Procedure: Vein graft	20
Extra Circumst: Hypothermia	5
Extracorporeal circulation	5
Physical Status:	2
Time: 4 3/4 hours -- regular	19
Bonus time	3
Other Procedures: Swans-Ganz	5
Arterial Needles	<u>5</u>
	64

Medicare indicated the Swans-Ganz was "included" and only paid for 59 units.

Because Dr. Stein practices outside the Indianapolis area he doesn't receive the time unit bonus, nor does he attend open heart surgery for which extracorporeal circulation or hypothermia is used. Thus, his impression is more guarded regarding Part B coverage of modifiers and extra procedures. He does

get patient severity modifier reimbursement and does get extra for arterial lines. All three physicians are selective as for which patients they accept assignment.

Dr. Stein practices in a hospital almost astride the state line and expressed concern that an anesthesiology RVU on the Indiana side is worth \$ 13.60, but 100 yards away in Illinois it is worth about \$16 and is \$16.50 in Michigan! He also reported that the ASA committee on Economics compared the 1973 guide with the 1981 ASA guide for each of 3696 surgical codes which could occur with either edition. These were then condensed to the 227 anesthesia codes for the 1981 guide - 334 of the surgical codes couldn't be compared since the procedure was either brand new or was obsolete and didn't appear in both 1973 and 1981. 2532 procedures produced the same RVUs with both systems. 304 had RVU decreases and 527 procedures showed an increase in the basic RVUs. Thus, the 1981 ASA guide was indicated not to be inflationary (at least in Indiana where the ASA modifiers are counted for reimbursement).

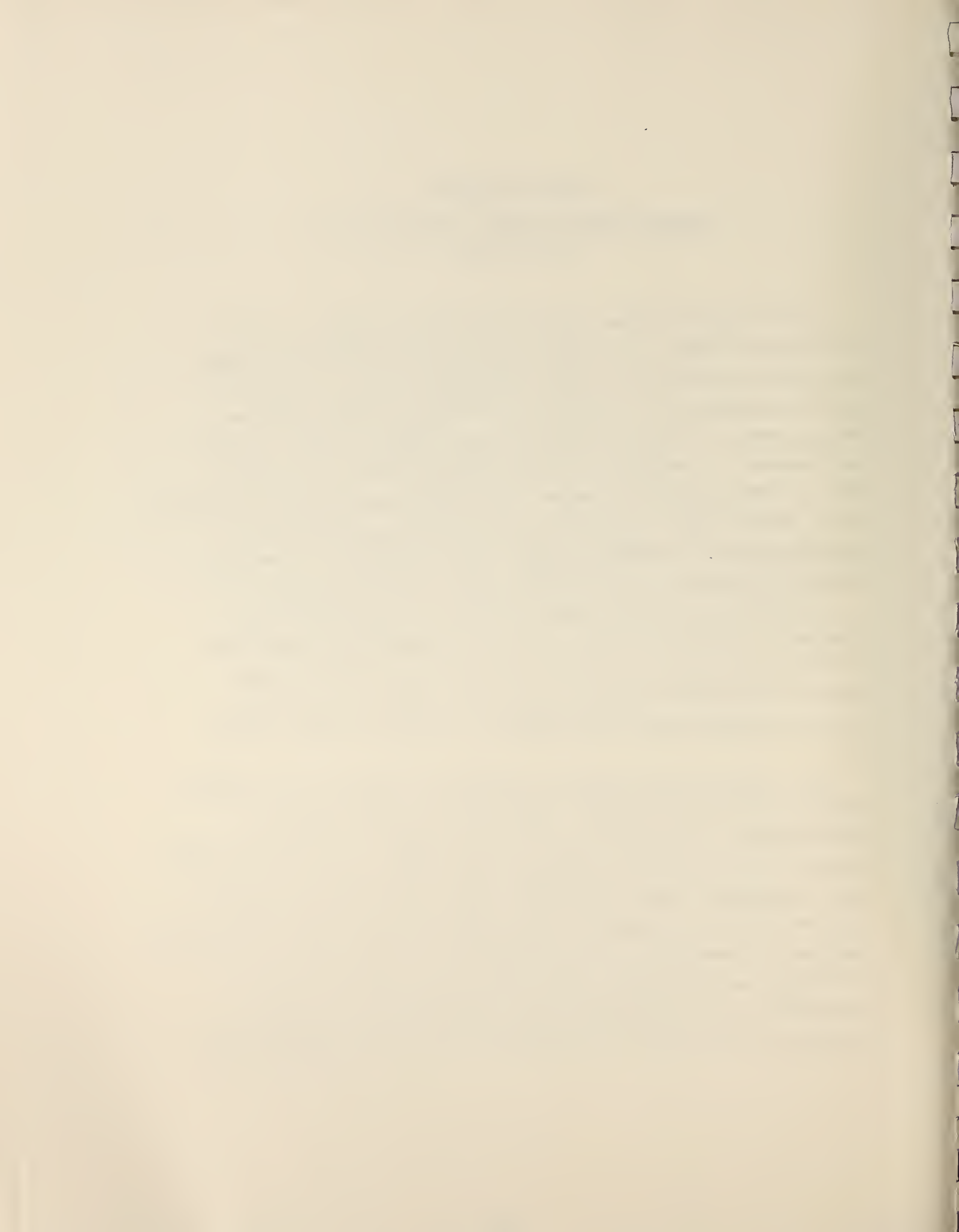
SITE VISIT REPORT

MEMORIAL MEDICAL CENTER, JACKSONVILLE, FL
July 9, 1985

We met with Dr. Beesom, an anesthesiologist in private practice, at the medical center. Dr. Beesom noted that none of the major payers in Florida use the ASA codes, but everybody does follow the FMA manual and this uniformity is a blessing (e.g. 47600 means cholecystectomy for all payers). When the 1982 FMA revision came out some of the RVUs were adjusted --- some went up (carotid endodartectomy), and some went down, but FMA defended the changes. Blue Shield doesn't pay for modifiers, but Dr. Beesom didn't seem to be too concerned and mentioned that he was surprised how often Medicare pays the full charge (he did mention that the 8-10 weeks it took to receive payment is a sore point).

A concern voiced by Dr. Beesom related to the major shift from inpatient to ambulatory surgery and the fact that the anesthesiologist typically doesn't get to see the patient until just before surgery. However, his experience has been very good in terms of the patients coming in without having eaten breakfast or lunch just before surgery, etc.

The operating room schedule at Memorial is posted in the afternoon together with the call schedule. Some patients request a specific anesthesiologist, but most go with the call schedule. The anesthesiologist thus has his or her list the afternoon before surgery with the patient's name, the surgeon's name, and a narrative description of the procedure. After the patient is released to the recovery room staff the anesthesiologist completes the anesthesia record and charge slip. The slip has a place for entering age and physical status but Dr. Beesom doesn't use all the modifiers since none of the payers recognize them. He codes the procedure in CPT-4 (FMA) from a handy short list of the 150 most common



procedures. He also enters the number of RVUs, the time units, and his total charge (regardless of what Medicare pays). The charge slips are sent to his office (Dr. Beesom only goes by the office infrequently). His partner does the same, also coding his own charge slips.

When several procedures were performed during the same trip to the OR, Dr. Beesom selects the procedure with the highest number of base units since it most affects the type and complexity of anesthesia. The time units make up for the other procedures. He noted that there are problems in finding the correct code when working with a podiatrist or hand surgeon since the procedures may not be indexed in the book at all. However, the RVUs for all hand procedures or all foot procedures are the same, so it doesn't really matter if the wrong code is used. If Medicare converts to the ASA codes it would have little affect on Dr. Beesom's practice.



SITE VISIT REPORT

The Mason Clinic, Seattle, Washington

July 22, 1985

The meeting was with Dr. William Horton, chief of anesthesiology at the Mason Clinic (a major kidney transplant center for the Northwest). Dr. Horton reported that few anesthesiologists in Washington accept assignment, but most will assist the patient by preparing the Medicare bill and submitting it to the carrier on behalf of the beneficiary. The history of anesthesia billing in Washington began with the earlier system (30 years ago) in which the surgeon and the anesthesiologist discussed fees and jointly decided how much each would charge. This became formalized as a set of anesthesia fees just as the surgeons' charges became formalized. When the ASA guidelines came along, they differed from the established fees -- in some cases the ASA RVUs were a "package price" and the insurer wouldn't pay extra for arterial lines or special monitoring (as in cardiac surgery, for example), while for other procedures the insurer considers arterial lines and other extras to be separately billable. Thus, reimbursement for anesthesia is complex in Washington.

Because much of the surgery at Mason is schedulable, the anesthesiologist usually meets the patient the day before surgery and gets the informed consent, does the pre-anesthesia assessment, and the preparation. About 80 percent of patients appear on the OR schedule the day before and are assigned an anesthesiologist if a specific one was not requested. There is some last minute shifting of assignments in some cases.

The patient is prepared in a holding area which serves all of the ORs. Here the catheters are inserted, IVs initiated, etc. The patient is then wheeled to the OR, anesthesia is induced, and surgery performed. The surgical time starts with the first cut and runs until the final suture and dressing is applied. The OR facility use time begins when the patient comes in the OR door until he or she leaves. Anesthesia time includes the preparation time, time in the OR, and the post operative



time until the patient responsibility is formally passed to the recovery room staff. In kidney transplant surgery the anesthesiologist may stay with the patient after surgery and transport the patient to the nuclear medicine department to be sure the kidney is functioning, then back to recovery before turning over responsibility.

After release of the patient the anesthesiologist completes the Anesthesia Record (see Exhibit 1). This includes:

- Documenting the name of the surgical procedure
- Documenting the anesthetic procedure
- Enumerating special types of anesthesia and extra procedures carried out (e.g. monitoring catheter with induced hypotension).

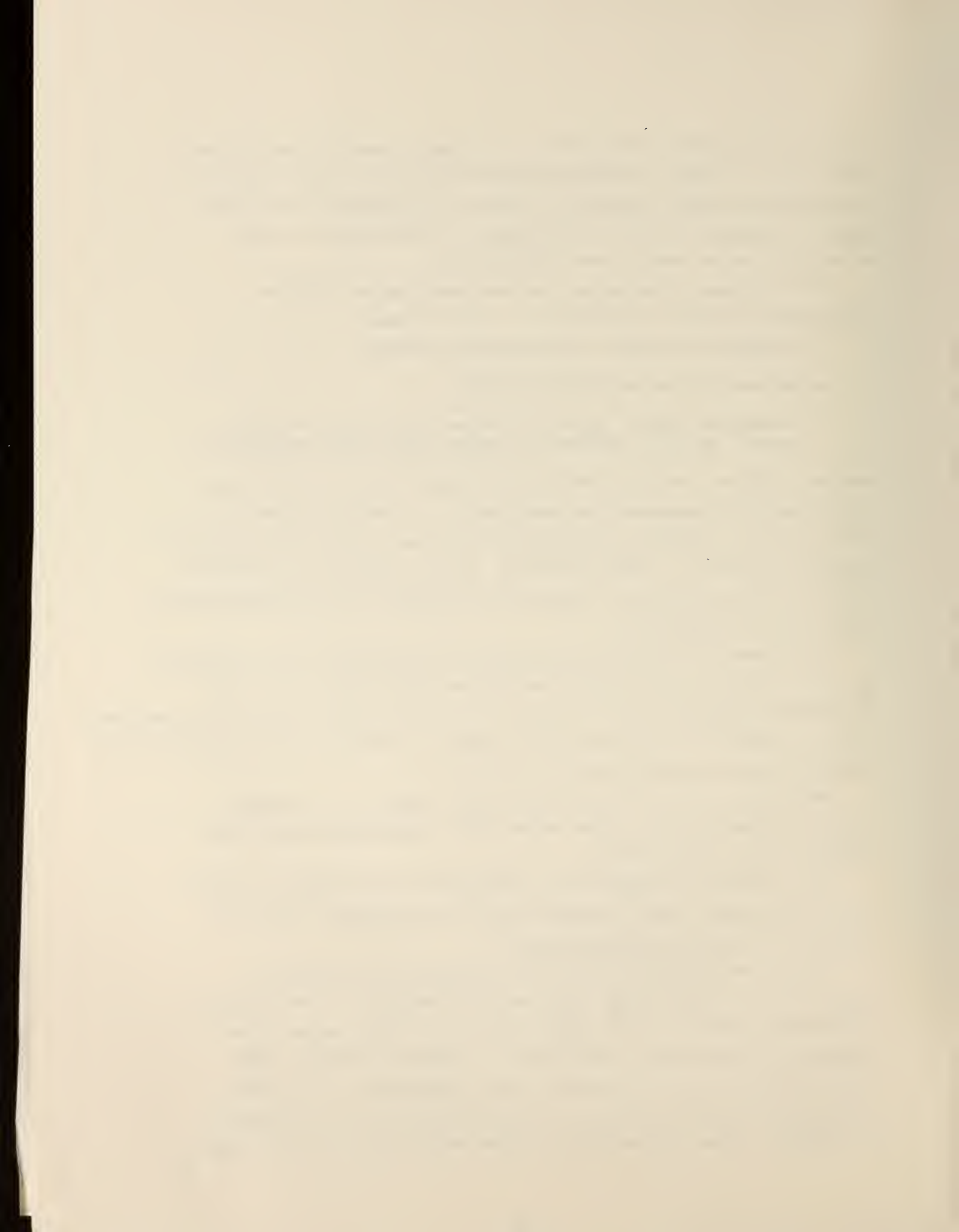
Base unit RVUs are assigned, based on the surgical procedure and cover the pre-operative assessment and anesthesia --- a version of the ASA guide is used. Modifiers are indicated for patient status and/or emergency procedure and result in additional RVUs. Extra procedures are indicated with their CPT codes and unit values (1980 ASA guide) on the anesthesiology charge slip (see Exhibit 2).

At the Mason Clinic the circulating nurse establishes what procedure(s) were done, looks it up in CPT, and enters the code in the OR log book. The anesthesiologist writes the narrative and CPT procedure codes in the anesthesia record, checks-off the monitors and equipment, enters ASA class (patient status), checks-off emergency, and writes in the time.

Each unit is worth \$26 right now for Dr. Horton --- a Swan-Ganz catheter (36010-30) has 10 units value (\$260), endotracheal intubation (31500-30) has 6 units (\$156).

After the bill is prepared it is submitted to the carrier on behalf of the beneficiary. When the beneficiary receives payment, he or she is expected to pay the anesthesiologist.

If only the ASA codes were used at the Mason clinic instead of the surgical procedure codes, there could be confusion. Kidney patients often have 2 operations on the same date and this would appear to be duplicate billing based on the ASA code --- surgical procedure codes would show that the second procedure was a complication. ASA codes also might not always indicate if a monitoring procedure was "included" or "extra" --- thus, the handling of these would have to also be changed.



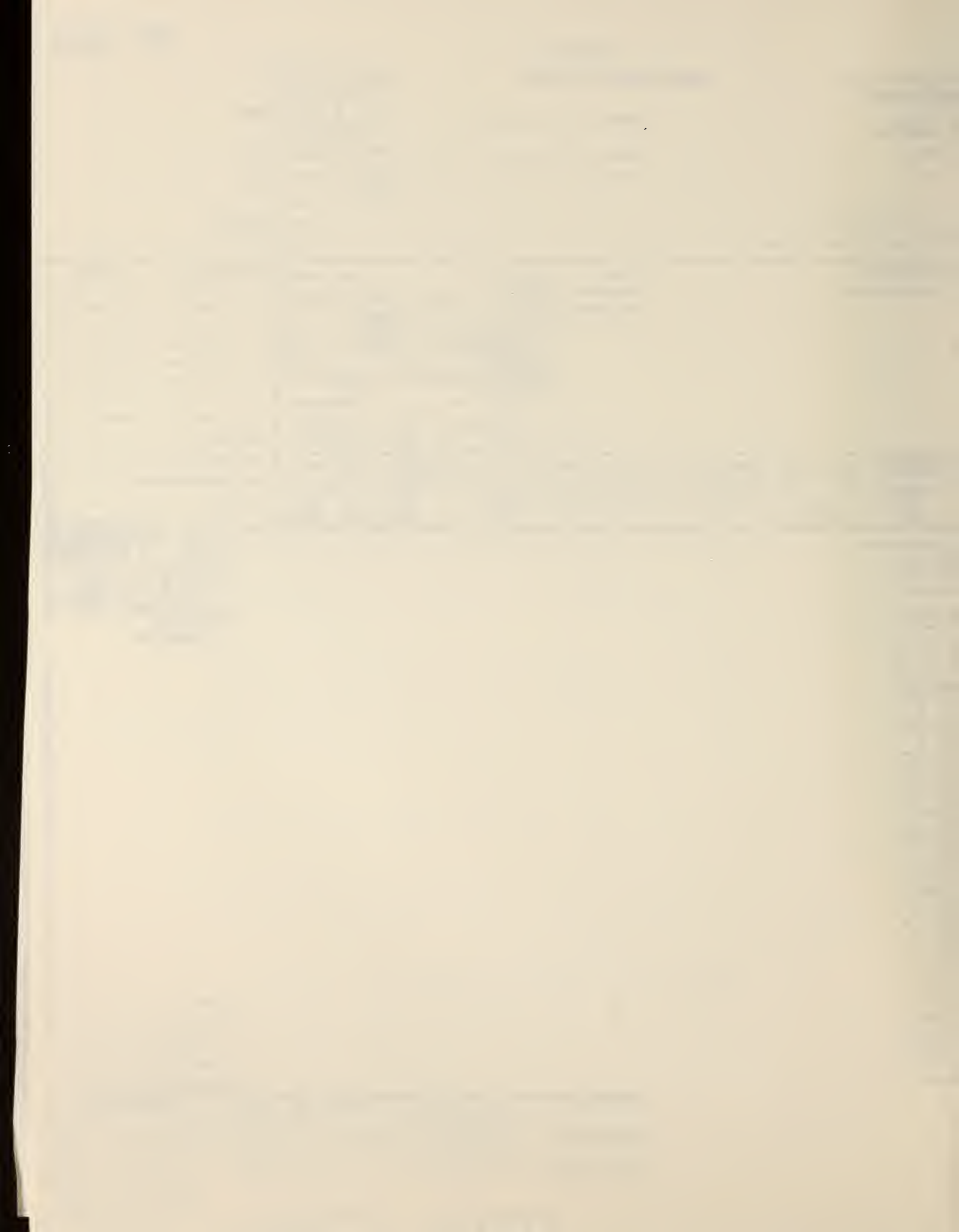


EXHIBIT 1 (continued)

Date

POST-OP VISIT:

ANESTHESIA RECORD COMPUTER CODES

PAIN BLOCKS
July 1, 1985

I. Local Anesthetic	Code
1. Intercostal - diagnostic	64420
post-op analg.	64421
2. Trigeminal N.	64400
3. Occipital N.	64405
4. Other peripheral N.	64450
5. Sympathetic - stellate	64510
6. celiac plexus	64530
7. paravertebral sym.	64520
8. lumbar sympath.	64520
9. Spinal	62274
10. Differential spinal	62276
11. Epidural	62278
II. Neurolytic (Alcohol or Phenol)	
1. Celiac plexus	64680
2. Trigeminal	64605
3. Spinal	62280
4. Other peripheral n.	64640
III. With hypertonic saline	
1. Subarachnoid	62280
IV. With steroids	
1. Subarachnoid	62288
2. Epidural	62289
3. Myofascial	
4. Other peripheral nerve	
V. Single Series (5-10) sympathetic blocks	
1. Stellate	64510
2. Lumbar	64520
VI. Continuous block (epidural catheter for sympathectomy or pain control)	
1. Day one	62279
2. Each succeeding day	62279
VII. Pain consult - without block	96000
1. Initial	
2. Follow-up	
VIII. Epidural Blood Patch	
1. Following our anesthetic	62273
2. Following myelography, etc.	62273
EXTRAOPERATIVE PROCEDURES	
Diagnostic lumbar puncture	62270
Permanent epidural catheter	64999
Endotracheal intubation	31500
Ventilation management	94656
Cardiac cath/picmnt catheter	93503
Arterial catheterization	36620
Central venous catheterization	36480
Swan-Ganz catheter	36010
Neonatal resuscitation	99152
Ureter test	99199
Post-op intercostal block	64421
Arg laser bronchoscopy	31659

PRIMARY TECHNIQUE:
LOCL = Local
LMON = Loc/Monitoring
GENA = General Anesthesia
SPIN = Spinal
CSPN = Continuous Spinal
EPID = Epidural
CEPI = Continuous Epidural
CAUD = Caudal
CCAU = Cont. Caudal
CATS = Caudal/Trans-sacral
AXIL = Axillary
SPCL = Supraclavicular
ISCA = Interscalene
IVRG = IV Regional
STEL = Stellate
SCFM = Sci/Femoral
3NLG = 3 Nerve Leg
4NLG = 4 Nerve Leg
PFOS = Popliteal Fossa
HRNA = Hernia
ICBS = Bil. ICB
ICBU = Uni. ICB
CPLX = Celiac Plexus
ICCP = ICB/CP
ICLS = ICB/Lumbar Somatic
OTHR = Other

Local Anesthetic Agents

10 = BU = bupivacaine (Marcaine)
11 = CP = chlorprocaine (nesacaine)
12 = DI = dibucaine (Nupercaine)
38 = ET = etidocaine (Duranest)
13 = LI = lidocaine (Xylocaine)
14 = MP = mepivacaine (Carbocaine)
16 = PL = propitocaine, prilocaine (Cita)
17 = PR = procaine (Novocaine)
18 = TE = tetracaine (Pontocaine)

Inhalation Agents

20 = HA = halothane
22 = N2 = nitrous oxide
23 = O2 = oxygen
25 = IS = isoflurane (Forane)
26 = EN = enflurane (Ethrane)

Barbiturates

40 = AM = amobarbital (Amytal)
41 = BR = methohexital (Brevital)
45 = TH = thiamylal (Surital)
46 = TP = thiopental (Pentothal)

Narcotics

61 = FN = fentanyl
62 = DE = meperidine (Demerol)
63 = MS = morphine
66 = SU = sufentanyl
67 = AL = alfentanyl

Neurolytic Agents

80 = OH = alcohol
81 = AS = ammonium sulfate
82 = PH = phenol

Miscellaneous Agent(s)

95 = BL = blood
97 = DM = corticoids (Depo-Medrol, etc.)
93 = SA = saline
99 = OT = other

PRIMARY AGENT

For general anesthesia, the maintenance agent is the primary agent. For regional block when two or more local anesthetic agents are mixed (compounded), the agent with the longest duration is the primary agent

The primary agent is the major (or longer acting) agent used for the primary technique. "Secondary agent" should describe use of general anesthetic to supplement a regional block, or muscle relaxant to supplement general anesthesia. Do not enter agents used for induction only.

CM / IN

188 -74

183 -72

178 -70

172.7 -68

167.6 -66

162.6 -64

157.5 -62

152.4 -60

139.7 -55

127 -50

114.3 -45

101.6 -40

88.9 -35

76.2 -30

PHYSICAL STATUS

- 1 = normal healthy patient
- 2 = patient with a mild systemic disease
- 3 = patient with a severe systemic disease that limits activity, but is not incapacitating
- 4 = patient with an incapacitating systemic disease that is a constant threat to life
- 5 = moribund patient not expected to survive twenty-four hours with or without surgery

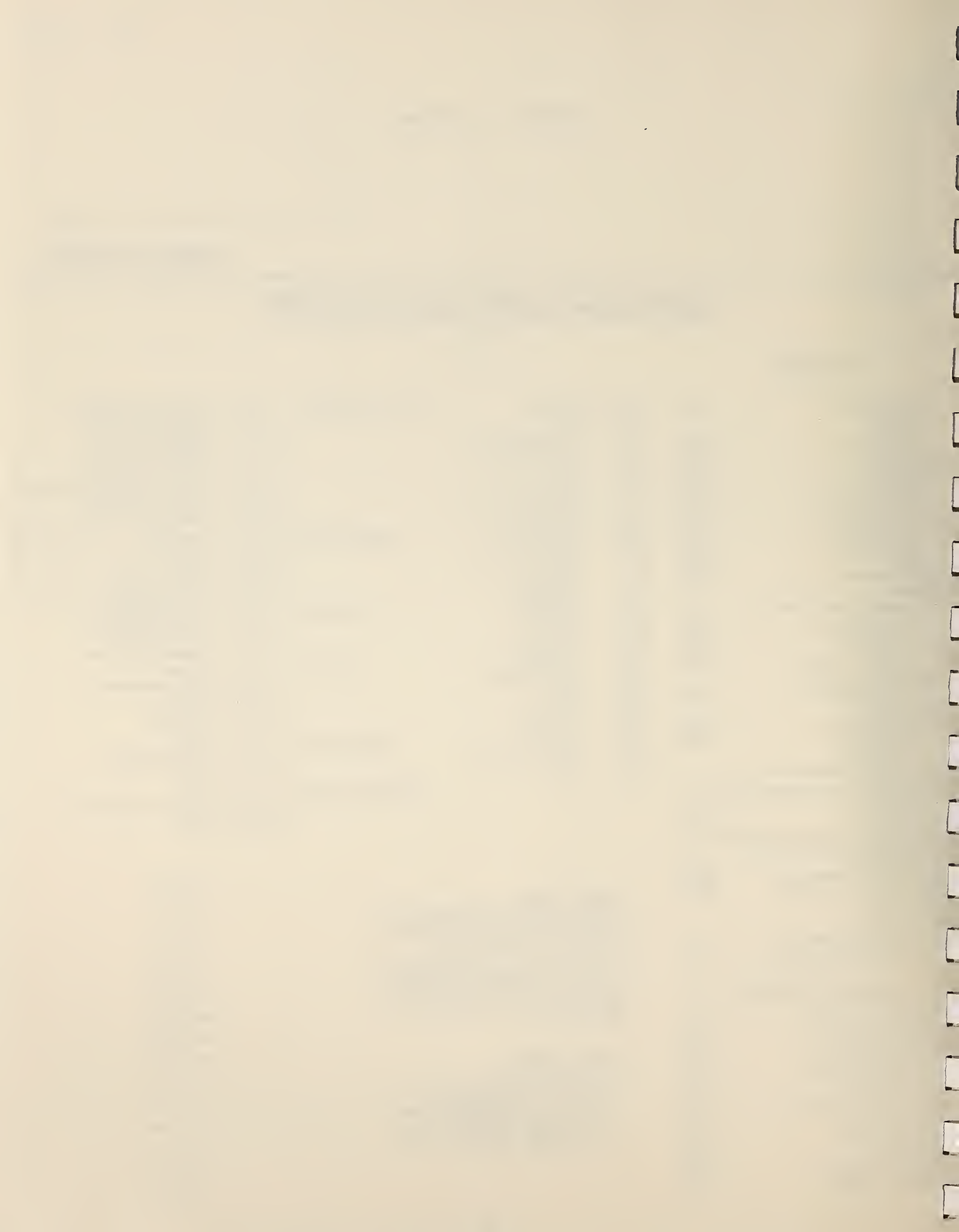


EXHIBIT 2

THE MASON CLINIC
ANESTHESIOLOGY EXTRAOPERATIVE PROCEDURES
CHARGE SLIP

M₂₂

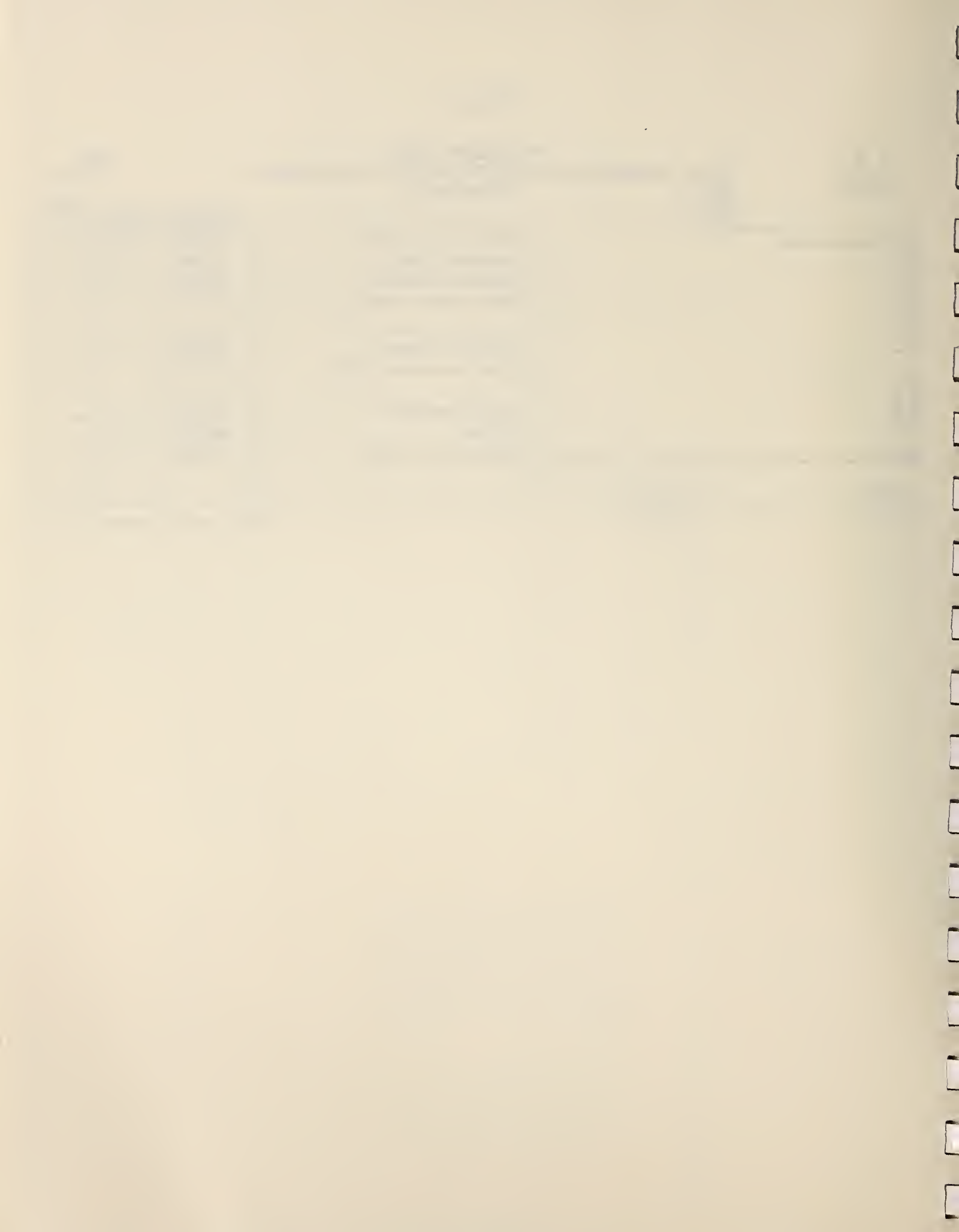
ASA ↓ ... 30 = anesthesia
general

2
PLACE OF
SERVICE

1	BUSINESS DATA PLATE
0	
0	
0	
0	
HOSPITAL NUMBER	
DATE	
RESIDENT:	BILLING #
STAFF:	BILLING #

DESCRIPTION OF SERVICE	PROCEDURE CODE	UNIT VALUE	✓
Endotracheal intubation	31500-30	8	
Ventilation management	94656-30	5	
Cardiac Cath/picmnt catheter	93503-30	10	
Arterial Catheterization	36620-30	3	
Central venous catheterization	36480-30	3	
Neonatal Resuscitation	99152-30	6	
Curare test	99199-30	6	
Post-op Intercostal block	64421-30	5	

C-01305 Anesthesia Hospital Visit Slip - Rev. 1-83



SITE VISIT REPORT

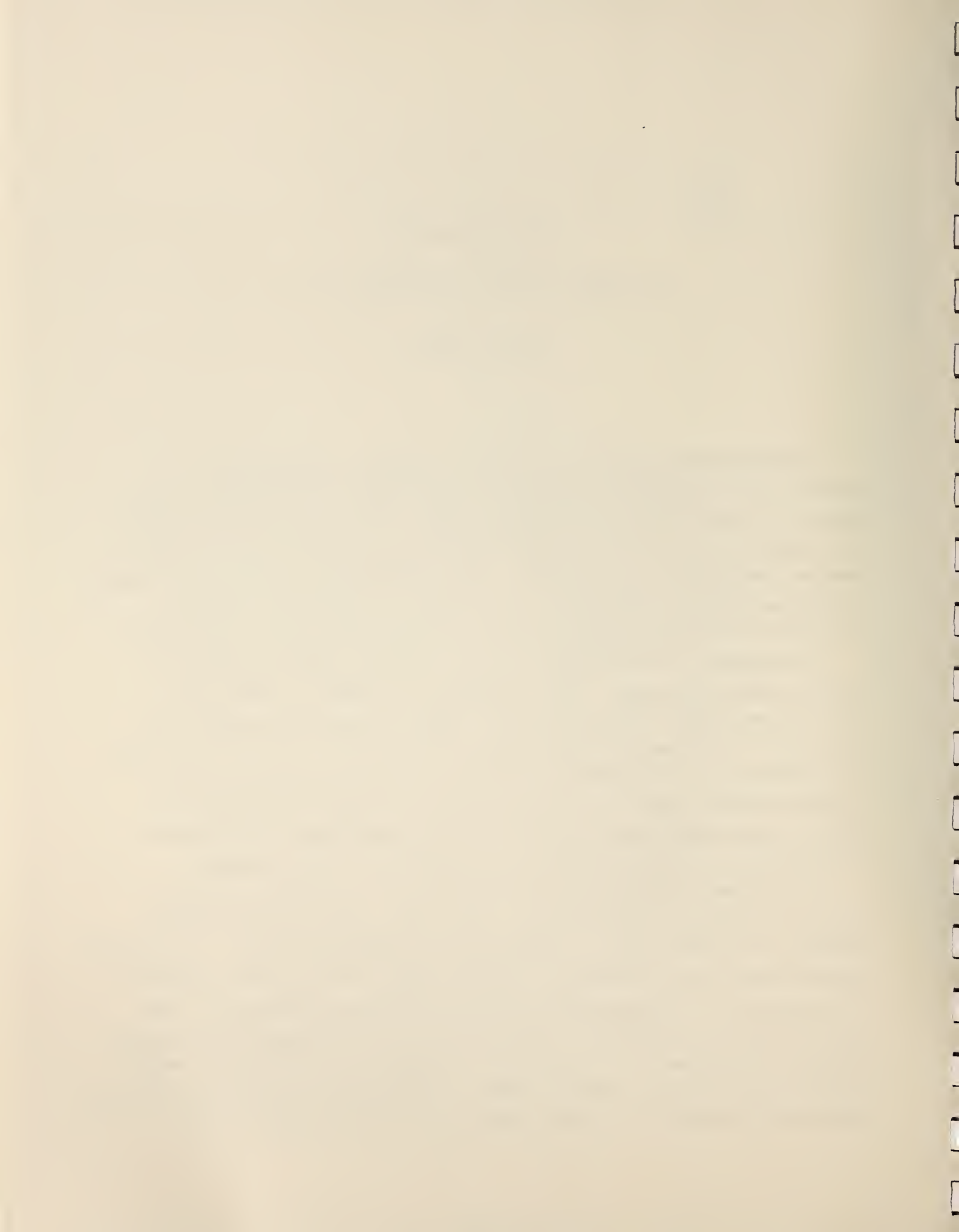
St. Francis Hospital, San Francisco, CA

July 24, 1985

The meeting took place at St. Francis Hospital with Hugh Vincent, MD, and Mr. G. William Eckert who operates "Northern California Anesthesia Office" (NCAO), a billing service for anesthesiologists. Dr. Vincent accepts assignments selectively, as do most California anesthesiologists. He provides very complete charge data on each patient to NCAO which then uses the data selectively to meet the differing requirements of each payer. Medicare is considered to be one of the worst problem payers by the anesthesiologists in California.

In California, the 1969 CRVS is used to determine RVUs for anesthesia on each surgical procedure. Prior to conversion to HCPCs in October 1984, the bills were coded using the 1974 CRVS codes--most anesthesiologists still report the '74 CRVS codes and NCAO converts these to CPT-4. None of the payers in California use the ASA 1982 codes--but Dr. Vincent says they are used in the Rocky Mountain states and they do increase the number of RVUs (this is offset by lower reimbursement per RVU, so is not inflationary, but does end up downgrading the percentage of total billing that is "time" related).

In California, Medicare will accept modifiers in some cases, but each submission requires a special report. Since NCAO is an on-line EMC service, sending in the special report is seen as very burdensome and costly. An unlisted procedure must also be handled by a special report involving manual handling--a big problem in California where many new procedures are developed. Time units are based on starting the clock when the anesthesiologist starts putting monitors in--continue until the patient is formally transferred to the responsibility of the recovery room nurse (NRO). All California payers except Medicare change from 15 minute to 10 minute time units at the beginning of the 5th



hour for any surgical procedure (e.g., after completion of the fourth hour, each additional hour, or fraction thereof, receives 6 units per hour). The Medicare prevailing limit on anesthesiology presently yields about 48 percent of UCR, according to Dr. Vincent, while surgeons are getting close to 85 percent.

When Dr. Vincent completes a charge slip for a patient, he enters the patient's name, address, insurance information, surgeon's name, time for anesthesia start/stop, RVS code and modifiers, he circles the patient status code (P1 --- P5) and, if P3 or above, briefly writes in what the problem was, checks off if the case was an emergency, and writes in if special monitoring (arterial needles, for example) or special circumstances apply (extracorporeal circulation, for example).

When the charge slip arrives at NCAO, information is keyed in based on who the payer is. Special reports are also prepared and sent in. The CRVS code is converted to a CPT code and narrative using a computer based look-up. With the conversion to HCPCS, the modifiers for Medicare have also changed (see Exhibit 1). The Medicare EMC billing screen only has space for two modifiers--one of which must be AA for anesthesia provided personally by the anesthesiologist, the other modifier being used for various other possible entries. In general, Medicare will not provide extra payment in California for arterial needles or insertion of a Swan-Ganz catheter when performed by the anesthesiologist also providing anesthesia service to the same patient that same day. This is different than for Blue Shield's private business, which does pay for unbundled charges.

When Blue Shield audits EMC for Medicare, they first come to NCAO and look at the charge tickets--if not satisfied, they then go to the anesthesia record at the hospital. Last visit to NCAO, the auditors pulled from 200-300 charge tickets (NCAO handles about 9000 Part B bills/month). NCAO retains the old charge slips for 4 years (since these slips have all of the data needed for recoding using the 1982 ASA guidelines, the study in California could almost be done just from NCAO files.

NCAO sends bills to Medicare even for unassigned claims, then also sends a billing advice to the beneficiary explaining that they have billed Medicare for anesthesiology, what the amount of the bill was, that Medicare will reimburse the beneficiary for a lesser amount, and that the beneficiary will then have to pay the entire billed amount.

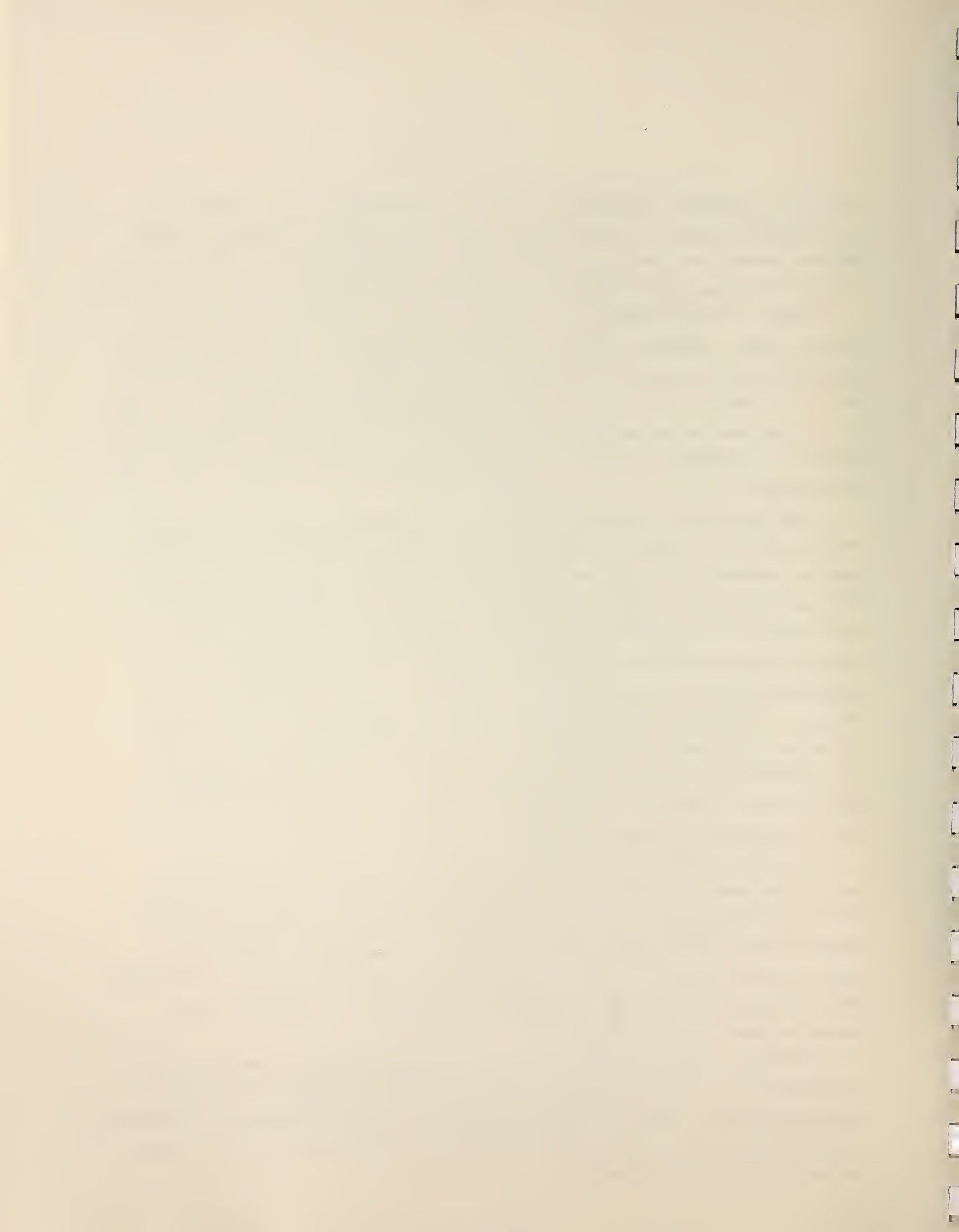


EXHIBIT 1

NORTHERN CALIFORNIA ANESTHESIA OFFICE

203 WILLOW STREET AT VAN NESS, SUITE 302
SAN FRANCISCO, CALIFORNIA 94109

July 10, 1985

MEMO TO CLIENTS

RE: Anesthesia Modifiers - Medicare

Listed below are the 1974 RVS modifiers and the corresponding HCPCS (CPT-4) modifiers. Please continue to use the RVS modifiers where they exist. If no RVS modifier feel free to use the HCPCS modifier - This applies to Medicare cases only.

Level of Direction Modifiers:

RVS Modifier	HCPCS Modifier	Description
30	AA	Anesthesia services personally furnished by anesthesiologist.

Risk and Special Circumstances Modifiers:

RVS Modifier	HCPCS Modifier	Description
	P1	A normal healthy patient.
	P2	A patient with mild systemic disease.
37	P3	A patient with severe systemic disease. The systemic disease, its severity and how it relates to the anesthetic must be noted on ticket under "modifier description." (If more space is needed use back of ticket).
38	P4	A patient with severe systemic disease that is a constant threat to life. The systemic disease, why it is a threat to life and how it relates to the anesthetic must be noted on ticket.
39	P5	A moribund patient who is not expected to survive for 24 hours with or without the operation. Description of patients condition demonstrating why they are not expected to live.

Note: Medicare will only allow up to 2 units for modifiers 37, 38 & 39 when properly described.

33	33	Anesthesia complicated by total body hypothermia.
32	WS	Anesthesia complicated by prone position or surgical avoidance.

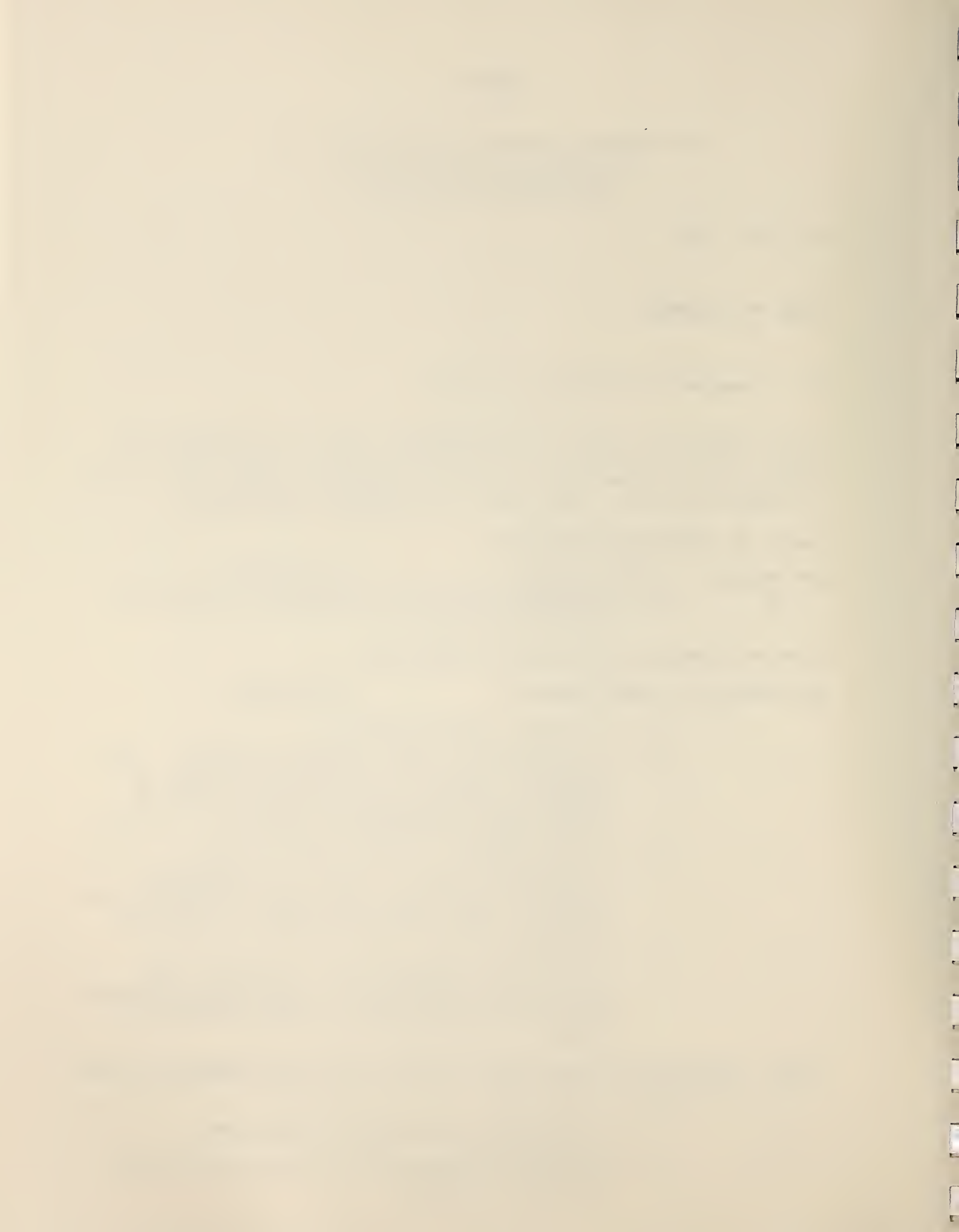


EXHIBIT 1 (continued)

NORTHERN CALIFORNIA ANESTHESIA OFFICE
 203 WILLOW STREET AT VAN NESS, SUITE 302
 SAN FRANCISCO, CALIFORNIA 94109

CONT'D: Anesthesia Modifiers - Medicare

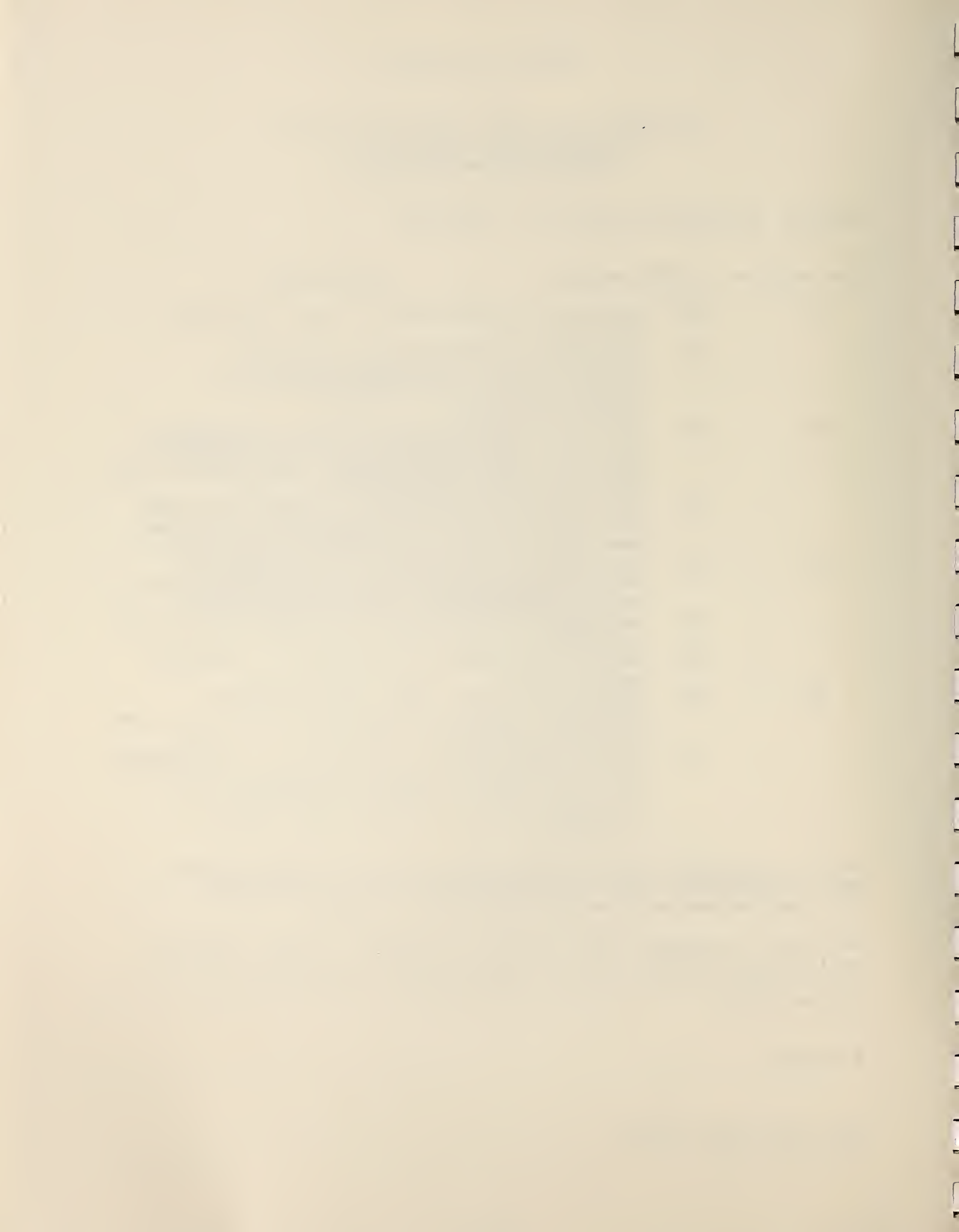
RVS Modifier	HCPCS Modifier	Description
35	WT	Anesthesia complicated by extra corporeal circulation.
	WX	Anesthesia complicated by hyperbaric pressurization. Describe the medical necessity for use of hyperbaric pressurization.
49	WZ	Multiple anesthesia modifiers. To be used when more than one risk or special modifier applies. Note each modifier that applies with explanation when necessary.
	XA	Anesthesia for patient of extreme age, under one year or over 70. Needs specific written description of how age affected anesthetic.
(33)	XB	Anesthesia complicated by utilization of controlled hypotension. Why did you have to control hypotension? Must be described.
	XC	Anesthesia complicated by emergency conditions (specify).
	W7	Service furnished in an ambulatory surgical center.
22	22	Unusual Services: When the service(s) provided is greater than that required for the listed procedure.
	23	Unusual Anesthesia: Occasionally, a procedure which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia.

Note: A specific written description of all "unusual service and circumstances" must accompany claims showing "unusual services/unusual anesthesia" modifiers (22 & 23).

Enclosed is a copy of CSA's letter of April 4, 1985; "Subject Medi-Cal Reimbursements" that may be helpful regarding 32,37,38 & 39 modifiers as both Medi-Cal and Medicare require similar documentation.

Sincerely

Bill and Dottie Eckert
 (415) 885-1657



SITE VISIT REPORT

St. Joseph's Hospital, Towson, MD

September 18, 1985

The visit to St. Joseph's was arranged with Gerald J. Carroll, MD, Chief of Anesthesiology. Dr. Carroll accepts Medicare assignment just as he does for Blue Shield "C". He has an arrangement with his accounting firm to also handle his billing, but some of the other anesthesiologists at St. Joseph's do their own billing or use another billing service. There are 10 general purpose OR rooms and one special procedures OR at St. Josephs, with 13 anesthesiologists in the department. Assignment of an anesthesiologist to a case is based on who is covering. Only the two anesthesiologists doing special procedures are excluded. The hospital also employs 3 full time CRNAs (2 in the day and 1 in the evening). There is an effort to rotate the anesthesiologists to work with different specialists--each gets breadth of experience with different types of cases.

When preparing the charge slip (see Exhibit 1) for a patient, Dr. Carroll enters the name, address, insurance information, diagnosis, surgical procedure (in narrative and CPT-4 code), RVUs, and total fees. Each charge slip is filled out in great detail, the same for all patients regardless of primary payer since Dr. Carroll can't be sure if the patient has a secondary payer with different requirements. The anesthesia record kept in the anesthesia department and patient record does have a check-off for ASA Patient Status (P1, 2, ---, 5). Dr. Carroll wasn't sure but thinks Medicare pays for P3+, so he puts the extra RVUs on the charge slip. He knows that Medicare doesn't pay extra for monitoring. If he inserts a Swan-Ganz catheter, he uses the CPT code and RVUs--he follows the billing instructions in the Blue Shield book. Open heart surgery is done at St. Joseph's, but some of the extras, such as hyperthermia, are almost never used.

Dr. Carroll currently charges \$25 per RVU, but the prevailing screen drops this to about \$18. For a D&C, the base value is 3 units, time is typically 40 minutes (3 units @ 15 min. each), so he bills 6 RVUs for \$150 and gets paid \$108 by Medicare. He doesn't find the current billing system to be much of a problem and generally knows what procedure the surgeon performed.



EXHIBIT 1

Mon. - Fri. 8:30 - 4:30

GERALD J. CARROLL, M.D.

Phone 667-9164

200 Padonia Road East
Timonium, Md. 21093

Name _____ Age _____ Date _____
Address _____
Bill To _____
Employer's Name _____ Emp. _____
Tel. _____
Fee _____ Billed _____ Tel. _____
Diagnosis _____
Operation _____
Anesthetic _____
Anes. Time _____
Surgeon _____ Date of Adm. _____
Ins. Co. Name _____ No. _____
Ins. Co. Name _____ No. _____
Date of Birth _____ S.S. No. _____

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